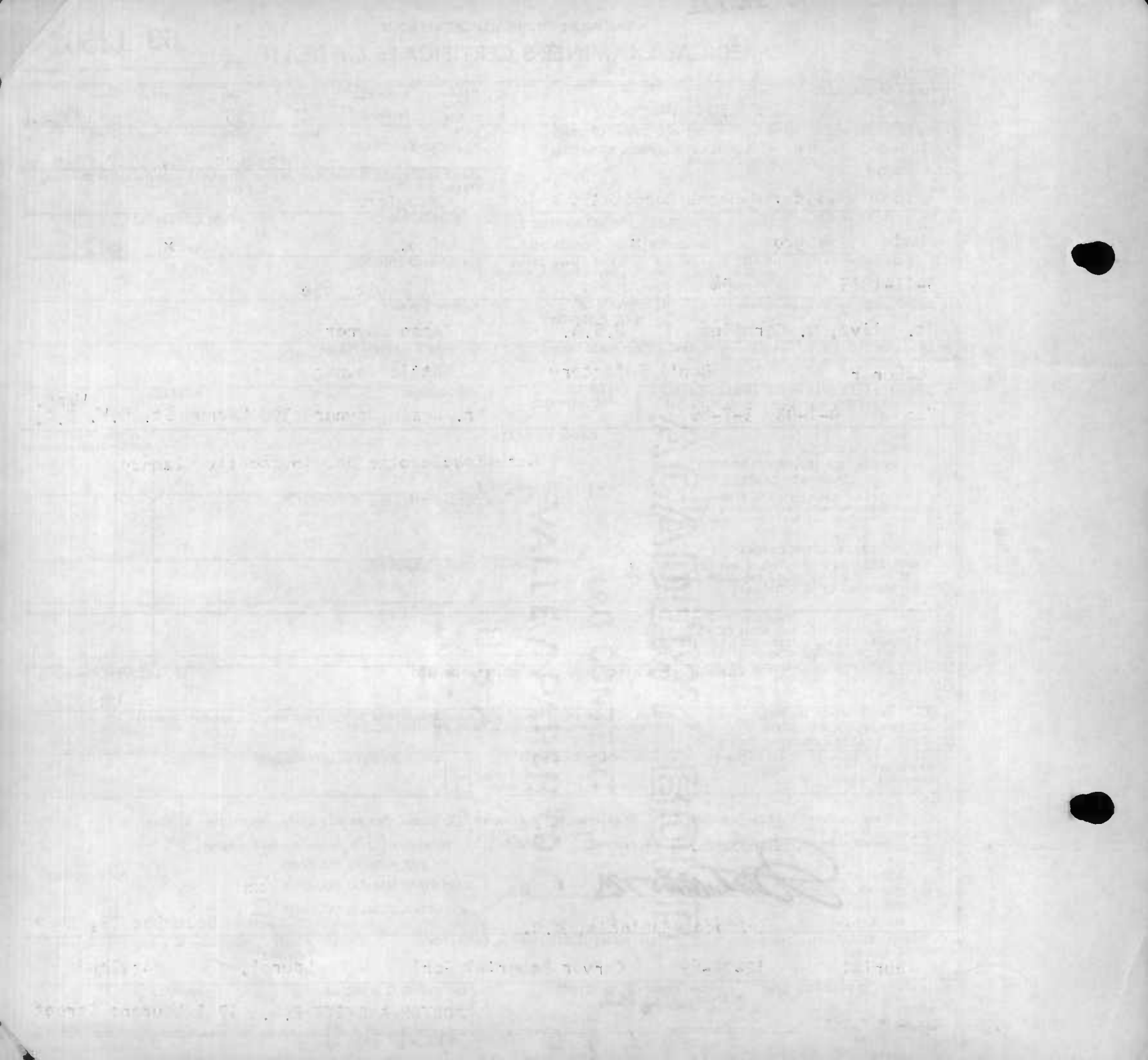


## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>JULIUS JOYNER</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour <b>12 16 69 6:29 p.m.</b>	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>South Balto. General Hospital</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>December 16, 1969 6:29 p.m.</b>	
6. SEX <b>Male</b>		7. RACE <b>Negro</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Balto.</b>	
9. DATE OF BIRTH <b>5-11-1915</b>		10. AGE (In years last birthday) <b>54</b>	
11. BIRTHPLACE (State or foreign country) <b>Mt. Olive, N. Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		14B. KIND OF BUSINESS OR INDUSTRY <b>Gen'l Refractory</b>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes 4-1-43 3-7-46</b>		17. SOCIAL SECURITY NO.	
18. INFORMANT <b>Mr. Jesse Joyner</b>		ADDRESS <b>Wash. 308 Varnum St. N.W. D.C.</b>	
19. CAUSE OF DEATH <b>Arteriosclerotic cardiovascular disease</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) DUE TO, OR AS A CONSEQUENCE OF:	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		(C) DUE TO, OR AS A CONSEQUENCE OF:	
20A. DATE OF OPERATION <b>2</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL EXAMINER'S NAME (Type) <b>Isidore Mihalakis, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12-20-69</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Carver Memorial Parl</b>		24D. LOCATION (City, town, or county) (State) <b>Laurel, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 18 1969</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>	
25C. FUNERAL DIRECTOR <b>MORTON &amp; DYETT F.H.</b>		ADDRESS <b>1701 Laurens Street</b>	

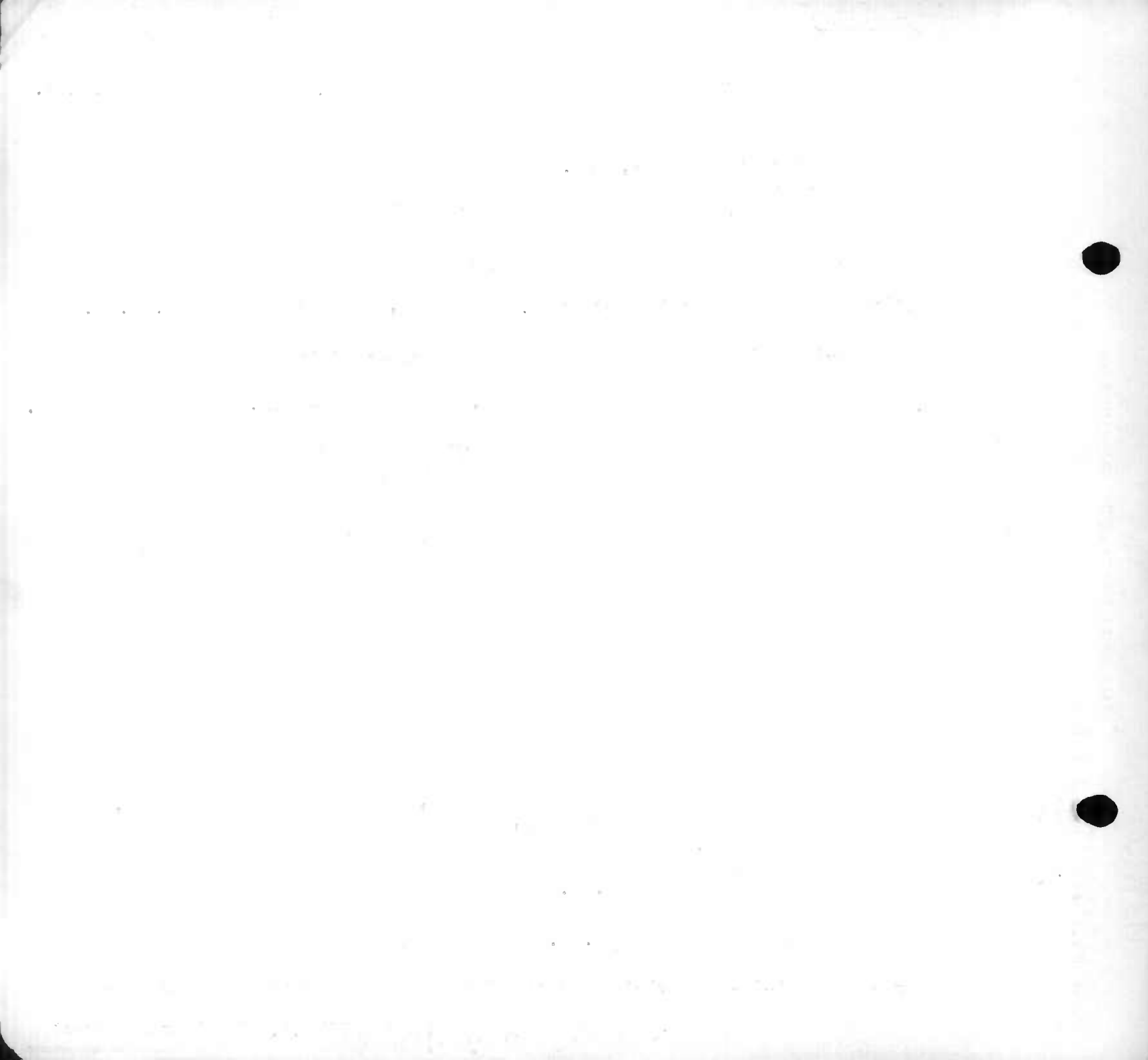




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <u>5-530</u> <u>69 12502</u>				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <u>69 12502</u>	
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
James Smith				12/15/69 10:40 a.m.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE		B. COUNTY	
39		Provident Hospital, Inc. 1514 Division Street Baltimore, Maryland 21217		Maryland		1302	
				C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
				Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER			
				2214 Callow Avenue			
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (in years last birthday)	10. Under 1 Yr. Months	11. Under 24 Hrs. Days	12. Under 24 Hrs. Min.
Male	Negro	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8/4/04	65			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Retired				Gas & Electric Co.		Baltimore, Maryland	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
David Hood				Rosana Smith			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No.						Mr. Archer Smith- Bro. 2020 Clifton Ave.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES				DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			
410.91				Cardiac Arrest due to VENTRICULAR Fibrillation			
				(B) ASHD - myocardial Infarction (x2)			
				DUE TO, OR AS A CONSEQUENCE OF:			
				1 yr & 5 wks			
				(C) _____			
II				OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
				No			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?		(If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from November 6, 1969 to December 15, 1969 that (I) (we) last saw the deceased alive on December 15, 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
Eliza H. SAUNDERS M. D.				12/15/69			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
Eliza H. SAUNDERS M. D.				2300 Garrison Blvd.			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		12-19-69		Arbutus Memorial Park		Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
DEC 18 1969		James F. ...		MORTON & DYETT F.H.		1701 Laurens Street	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>69 12503</u>	
BIRTH NO. <u>5-556 69 12503</u>		<b>CERTIFICATE OF DEATH</b>			
1. NAME OF DECEASED (Type or Print) <u>SILAS SIMON</u>		2. DATE AND HOUR OF DEATH <u>DECEMBER 16, 1969</u> <u>2</u> <u>37</u> P. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>806</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>42 SINAI HOSPITAL OF BALTIMORE, MD</u>		C. CITY OR TOWN <u>BALTIMORE</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER <u>1710 N. WOLFE ST # 13</u>			
5. SEX <u>MALE</u>	6. RACE <u>NEGRO</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>10/4/11</u>	9. AGE (In years last birthday) <u>58</u>	10. Under 1 Yr. Months: Days: 11. Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>STEEL</u>		11. BIRTHPLACE (State or foreign country) <u>NORTH CAROLINA</u>	
12. CITIZEN OF WHAT COUNTRY? <u>UNITED STATES</u>		13. FATHER'S NAME <u>Donel Simon</u>			
14. MOTHER'S MAIDEN NAME <u>Hattie Allen</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO.</u>			
16. SOCIAL SECURITY NO. <u>216-61-7200</u>		17. INFORMANT <u>Mr. Frank Williams SS</u>			
ADDRESS <u>Abington Ave</u>					
18. CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <u>I</u> <u>PULMONARY EMBOLISM</u> (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u> <u>TUMOR EMBOLISM</u> <u>CARCINOMA OF THE PROSTATE</u>					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>NO</u>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) 1 Month ( ) Day ( ) Year ( ) Hour ( )		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <del>the</del> (this hospital) attended the deceased from <u>DEC. 7</u> 19 <u>69</u> to <u>DEC. 16</u> 19 <u>69</u> that <del>the</del> (we) last saw the deceased alive on <u>DEC. 16</u> 19 <u>69</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. <del>the</del> (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Raymond P. Mademan M.D.</u>		23B. DATE SIGNED <u>12/16/69</u>		23C. PHYSICIAN'S NAME (Type) <u>Raymond P. Mademan M.D.</u>	
23D. ADDRESS <u>1701 Laurens St.</u>		23E. DEGREE <u>MD</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>12/19/69</u>		24C. NAME OF CEMETERY or CREMATORY <u>Simon Cemetery</u>	
24D. LOCATION <u>N.C.</u>		24E. FUNERAL DIRECTOR <u>Trappes</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>DEC 18 1969</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>		25C. ADDRESS <u>1701 Laurens St.</u>	

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1. The first part of the report is devoted to a description of the work done during the year. This includes a summary of the progress made in the various projects, and a detailed account of the results obtained. The second part of the report is devoted to a discussion of the work done during the year. This includes a summary of the progress made in the various projects, and a detailed account of the results obtained.

2. The second part of the report is devoted to a discussion of the work done during the year. This includes a summary of the progress made in the various projects, and a detailed account of the results obtained.

3. The third part of the report is devoted to a discussion of the work done during the year. This includes a summary of the progress made in the various projects, and a detailed account of the results obtained.

4.

5. The fifth part of the report is devoted to a discussion of the work done during the year. This includes a summary of the progress made in the various projects, and a detailed account of the results obtained.

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="background-color: black; color: black;">[REDACTED]</span>
S-300		69 12504		69 12504
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>SCOTT William</i>		2. DATE AND HOUR OF DEATH <i>11-13-69 6:45 P.M.</i>
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>MD.</i> B. COUNTY <i>Balti.</i> C. CITY OR TOWN <i>Baltimore</i> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <i>2403 1213 Light St.</i>		
FULL NAME OF HOSPITAL OR INSTITUTION <i>HARBOR VIEW N.C.C.</i>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		
5. SEX <i>M</i>	6. RACE <i>C</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>11-15-94</i>	9. AGE (In years last birthday) <i>73</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>118-10-5367</i>		17. INFORMANT
18. <i>412.4</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Arteriosclerotic Cardio Vascular Disease</i> <i>Cerebro Vascular Accident</i> <i>&amp; right Hemiparesis</i> (B) DUE TO, OR AS A CONSEQUENCE OF: <i>Amputated right foot</i> (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>?</i> <i>?</i> <i>?</i>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>No</i>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that <del>this</del> (this hospital) attended the deceased from <i>10-30</i> 19 <i>69</i> to <i>11-13</i> 19 <i>69</i> , that <del>we</del> (we) last saw the deceased alive on <i>11-13</i> 19 <i>69</i> and that in <del>our</del> (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <i>Rolando V. Goco</i>		23B. DATE SIGNED <i>11-13-69</i>		23C. PHYSICIAN'S NAME (Type) <i>Rolando V. Goco</i>
23D. ADDRESS <i>1213 Light St.</i>		24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		
24B. DATE <i>11-17-69</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Sharp Methodist C. Benger</i>		24D. LOCATION (City, town, or county) (State) <i>Indl.</i>
25A. DATE REC'D BY HEALTH DEPT. <i>DEC 19 1969</i>		25B. NAME OF REGISTRAR <i>John C. [REDACTED]</i>		25C. FUNERAL DIRECTOR <i>1922 Edmondson</i>

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## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 69 12505

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>Franklin Paul ANDREW BEATY</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour <b>12 11 69 9:30 P.M.</b>	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>38 University Hospital</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>December 11, 1969 9:30 P.M.</b>	
5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>26 42</b>			
6. SEX <b>Male</b>	7. RACE <b>White</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	C. CITY OR TOWN <b>Balto.</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
9. DATE OF BIRTH <b>1/28/24</b>		10. AGE (In years lost birthday) <b>45</b> If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>John Beaty</b>		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
15. MOTHER'S MAIDEN NAME <b>Anna May Edwards</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>	
17. SOCIAL SECURITY NO. <b>218-18-2223</b>		18. INFORMANT <b>Mary Coccagna Beaty, wife, above</b>	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Arteriosclerotic cardiovascular disease</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION <b>2</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) <b>YES</b>			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <b>Isidore Mihalakis, M.D.</b> CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) <b>Isidore Mihalakis, M.D.</b> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> <b>12/12/69</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>12/15/59</b>	24C. NAME OF CEMETERY or CREMATORY <b>Lake View Mem. Cem.</b>	24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 19 1969</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor, M.D.</b>	
25C. FUNERAL DIRECTOR <b>Schimunek Funeral Home, Inc.</b>		ADDRESS <b>3381 Brehms Lane</b>	

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VALLEY

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

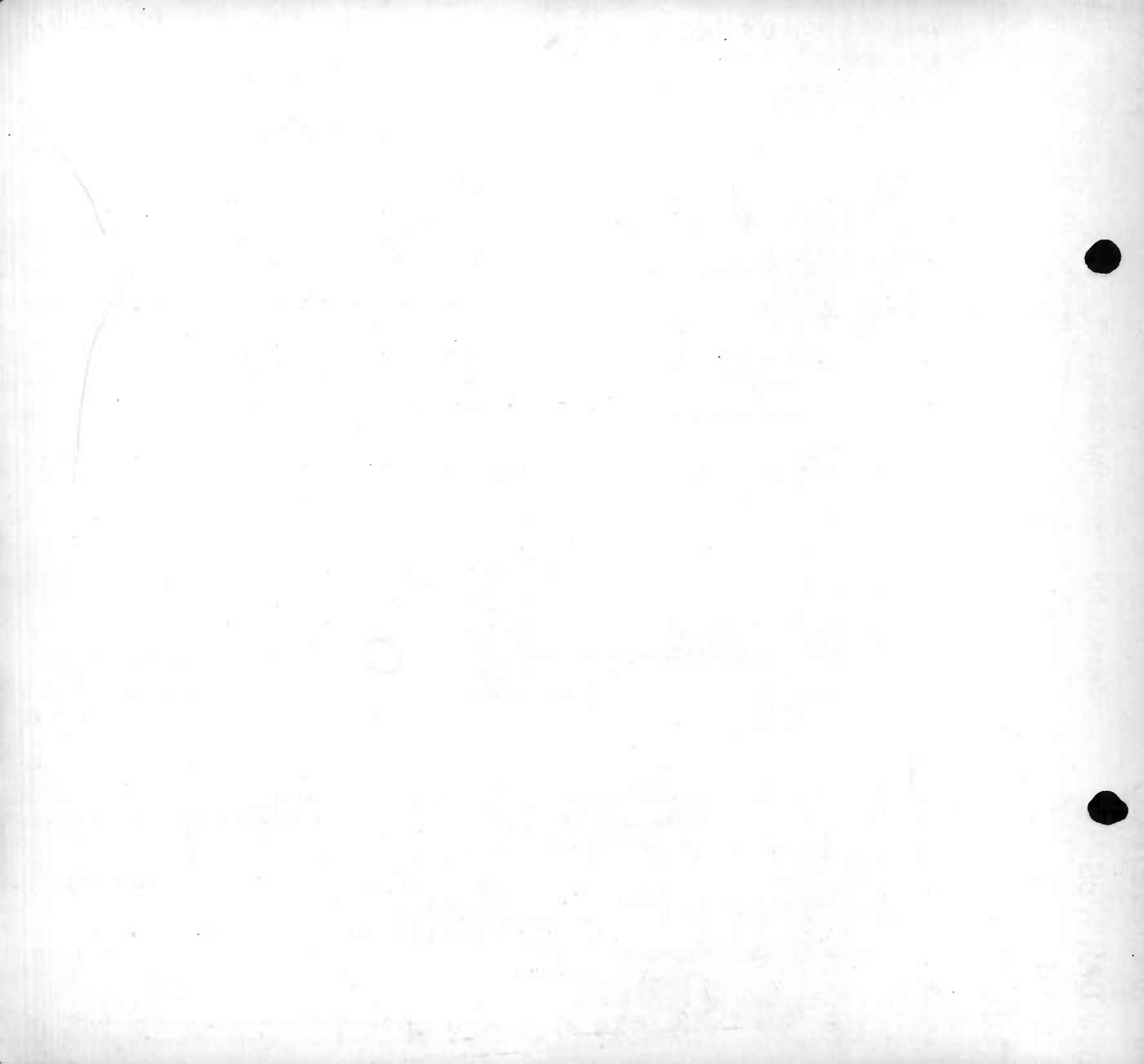
BIRTH NO. <u>D-155</u>		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <u>69 12506</u>	
1. NAME OF DECEASED (Type or Print) <u>LELIA Debnam</u>			2. DATE AND HOUR OF DEATH <u>12-17-1969</u> <u>7:15</u> P. M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <u>7 Mercy</u>			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>1207</u>		
FULL NAME OF HOSPITAL OR INSTITUTION <u>7 Mercy</u>			C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			E. STREET AND NUMBER <u>2732 Fox St.</u>		
5. SEX <u>F</u>	6. RACE <u>N</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-16-91</u>	9. AGE (in years last birthday) <u>78</u>	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Youngsville, N. Carolina</u>
13. FATHER'S NAME <u>David Yarbrough</u>			14. MOTHER'S MAIDEN NAME <u>Zelia ?</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>			16. SOCIAL SECURITY NO.		17. INFORMANT <u>2732 Fox Street</u> <u>Pauline Debnam Yelverton</u>
18. <u>250.9 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>congestive heart failure</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>diabetes mellitus</u>			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>12-17-1969</u> to <u>12-17-1969</u> that (I) (we) last saw the deceased alive on <u>12-17-1969</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>H - Makipour</u>				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) <u>Houshang - Makipour</u>				23D. ADDRESS <u>1735 Harford Ave. 21213</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>12-22-69</u>		24C. NAME of CEMETERY or CREMATORY <u>Mt. Auburn Cemetery</u>	
24D. LOCATION <u>Baltimore, Maryland</u>		25A. DATE REC'D BY HEALTH DEPT. <u>DEC 19 1969</u>			
25B. NAME OF REGISTRAR <u>Robert E. Jones, Jr.</u>		25C. FUNERAL DIRECTOR <u>Marshall W. Jones, Jr.</u>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<div style="display: flex; justify-content: space-between;"> <span>B-200 69 12507</span> <span>BALTIMORE CITY HEALTH DEPARTMENT</span> <span>REG. NO. 69 12507</span> </div> <h2 style="text-align: center;">CERTIFICATE OF DEATH</h2>			
1. NAME OF DECEASED (Type or Print) <u>BASS, Carrell</u>		2. DATE AND HOUR OF DEATH <u>12/17/69</u> <u>11:05 pm.</u> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>ANNELLEN RD.</u>	
FULL NAME OF HOSPITAL OR INSTITUTION <u>46 LUTHERAN HOSP.</u>		C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> <u>1511</u>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		E. STREET AND NUMBER <u>3931 ANNELLEN RD.</u>	
5. SEX <u>MALE</u>	6. RACE <u>NEGRO</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/7/37</u>
9. AGE (In years lost birthday) <u>32</u>		10. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CAB DRIVER</u>		10B. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>BOWDON NC</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>LLOYD B. BASS</u>		14. MOTHER'S MAIDEN NAME <u>MAGGIE BLOUNT</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>239-56-3499</u>	
17. INFORMANT <u>BONNIE BASS</u>		ADDRESS <u>8931 ANNELLEN RD.</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>Cardio resp. arrest</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>30 hrs.</u>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Diabetic audosis</u>		(B) DUE TO, OR AS A CONSEQUENCE OF: <u>Diabetes mellitus</u>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>acute relapsing pancreatitis</u>		(C) DUE TO, OR AS A CONSEQUENCE OF: <u>Dehydration: electrolyte disturbances</u>	
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY (Yes or No) <input checked="" type="checkbox"/>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>12/16/1969</u> to <u>12/17/1969</u> , that (I) (we) last saw the deceased alive on <u>12/17/1969</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <u>Subash C. Ahuja M.D.</u>		23B. DATE SIGNED <u>12/17/69</u>	
23C. PHYSICIAN'S NAME (Type) <u>SUBASH C. AHUJA, M.D.</u>		23D. ADDRESS <u>Lutheran Hospital, Baltimore</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burned</u>		24B. DATE <u>12/22/69</u>	
24C. NAME OF CEMETERY OR CREMATORY <u>MT AUBURN</u>		24D. LOCATION (City, town, or county) (State) <u>BALTO MD</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>DEC 19 1969</u>		25B. NAME OF REGISTRAR <u>John P. Hays</u>	
25C. FUNERAL DIRECTOR <u>John P. Hays</u>		ADDRESS <u>638 D Gilman St</u>	





11-460

69 12508

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

69 12508

BIRTH NO.

REG. NO.

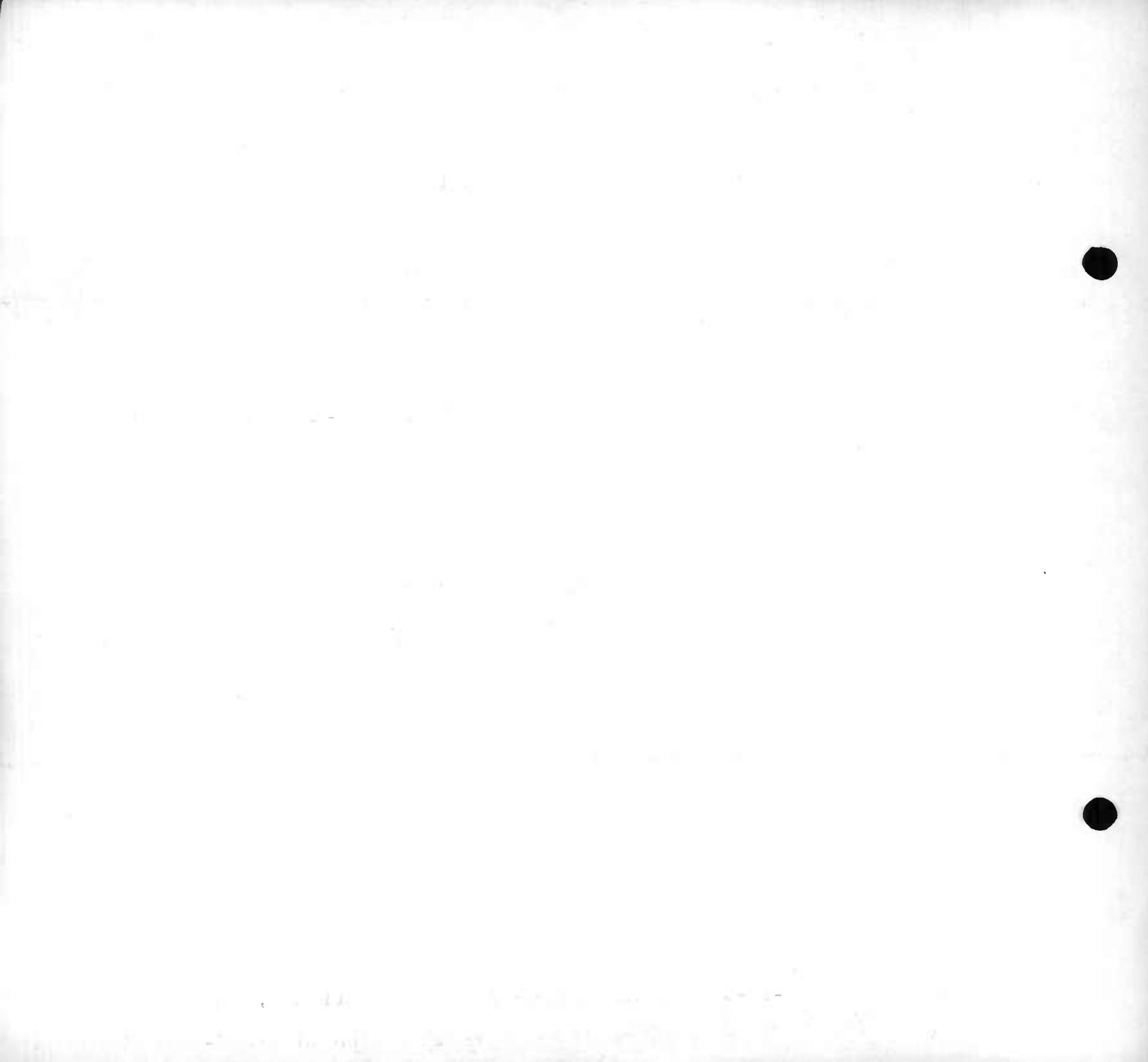
1. NAME OF DECEASED (Type or Print) <b>WILLIAM MILLER</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour <b>12 5 69 11:55 a.m.</b>	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>248 S. Conkling St.</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>Dec. 5, 1969 11:55a m.</b>	
5. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>2608</b>			
6. SEX <b>Male</b>	7. RACE <b>White</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	C. CITY OR TOWN <b>Balto.</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
9. DATE OF BIRTH <b>12/23/93</b>	10. AGE (In years lost birthday) <b>75</b>	E. STREET AND NUMBER <b>248 S. Conkling St.</b>	
11. BIRTHPLACE (State or foreign country) <b>Balto Md.</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	13. FATHER'S NAME <b>—</b>	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>retired</b>	14B. KIND OF BUSINESS OR INDUSTRY	15. MOTHER'S MAIDEN NAME <b>—</b>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>yes WW II</b>	17. SOCIAL SECURITY NO. <b>219-22-1614</b>	18. INFORMANT ADDRESS	
19. CAUSE OF DEATH <b>412.4 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Arteriosclerotic cardiovascular disease</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>(A) IMMEDIATE CAUSE</b> <b>DUE TO, OR AS A CONSEQUENCE OF:</b> <b>(B)</b> <b>DUE TO, OR AS A CONSEQUENCE OF:</b> <b>(C)</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
20A. DATE OF OPERATION	20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	21. AUTOPSY? (Yes or No) <b>no</b>	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	22C. WHERE DID (if in Baltimore City, give exact location) INJURY OCCUR?	
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)	22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <b>Isidore Mihalakis, M.D.</b> CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) <b>Isidore Mihalakis, M.D.</b> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <b>12/5/69</b> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>12/19/69</b>	24C. NAME OF CEMETERY or CREMATORY <b>Balto Nat'l</b>	24D. LOCATION (City, town, or county) (State) <b>Balto Md</b>
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 19 1969</b>	25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>	25C. FUNERAL DIRECTOR <b>John J. ...</b>	ADDRESS <b>263 S Conkling St</b>

ACAPBIR 120000

FUNERAL DIRECTOR: IMPORTANT

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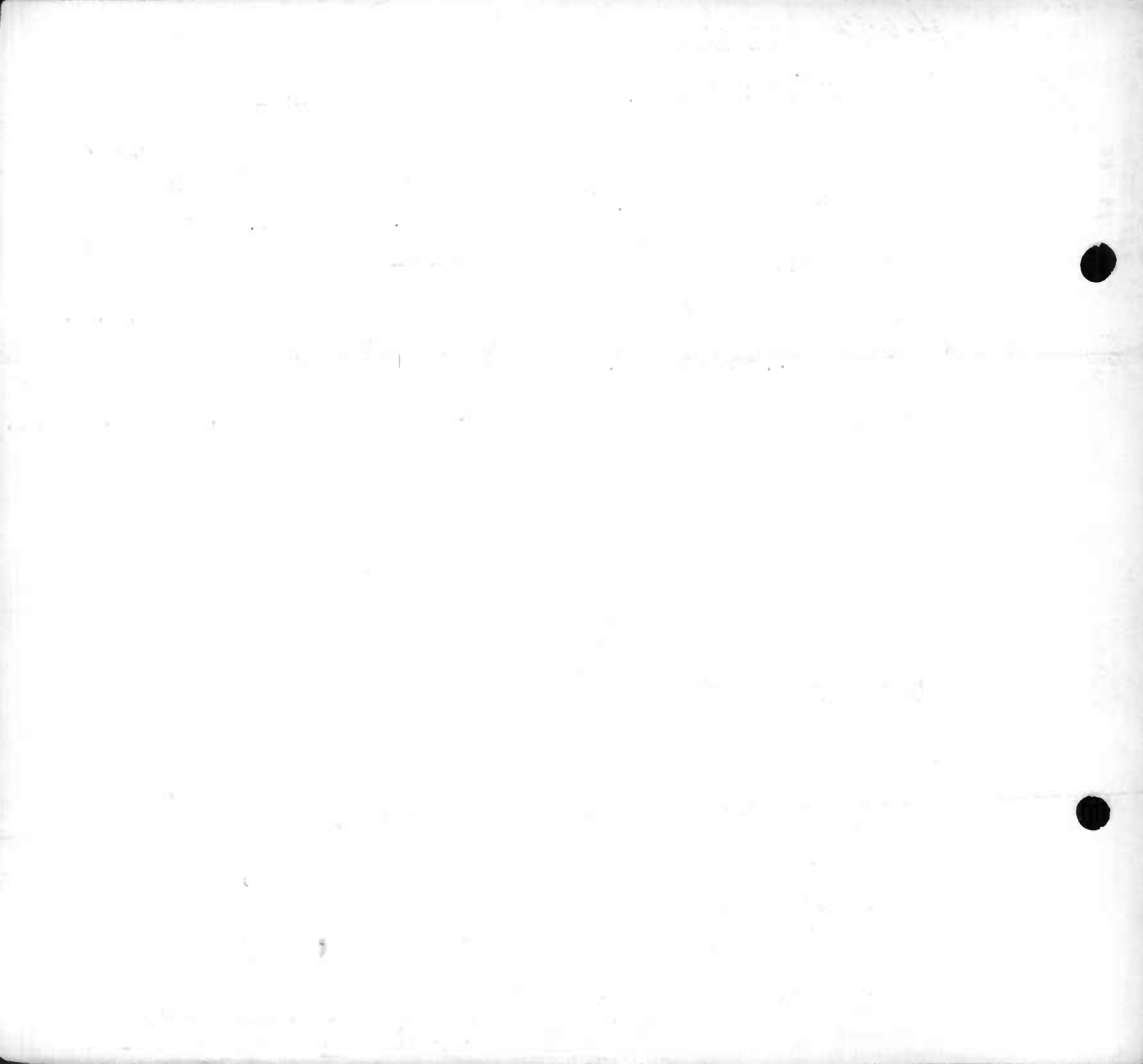
<p style="font-size: 24pt; margin: 0;">5-365</p> <p style="font-size: 24pt; margin: 0;">69 12509</p>		<p style="margin: 0;">BALTIMORE CITY HEALTH DEPARTMENT</p> <p style="margin: 0;">CERTIFICATE OF DEATH</p>		<p style="margin: 0;">REG. NO. 69 12509</p>	
<p>BIRTH NO.</p>		<p>1. NAME OF DECEASED (Type or Print) <b>MR. ANTHONY G. STRUNGE</b></p>		<p>2. DATE AND HOUR OF DEATH <b>12-16-69 9:30 A.M.</b></p>	
<p>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</p> <p>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>Bon Secours Hospital 2025 W. Fayette Balto, Md 21223</b></p>				<p>4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)</p> <p>A. STATE <b>BALTO</b> B. COUNTY <b>MD</b></p> <p>C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></p> <p>E. STREET AND NUMBER <b>5000 Cordelia Ave 2798</b></p>	
<p>5. SEX <b>Male</b></p>	<p>6. RACE <b>White</b></p>	<p>7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p>	<p>8. DATE OF BIRTH <b>08/08/24/03</b></p>	<p>9. AGE (In years last birthday) <b>66</b></p>	<p>If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.</p>
<p>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Printer</b></p>		<p>10B. KIND OF BUSINESS OR INDUSTRY</p>		<p>11. BIRTHPLACE (State or foreign country) <b>Maryland</b></p>	
<p>12. CITIZEN OF WHAT COUNTRY? <b>American</b></p>		<p>13. FATHER'S NAME <b>George Strunge</b></p>		<p>14. MOTHER'S MAIDEN NAME <b>Beulat</b></p>	
<p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b></p>		<p>16. SOCIAL SECURITY NO. <b>213-01-2506</b></p>		<p>17. INFORMANT <b>Thelda Strunge - 5000 Cordelia Avenue # 15</b></p>	
<p>18. <b>410.9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</p> <p>(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)</p> <p>ANTECEDENT CAUSES</p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p> <p>(A) IMMEDIATE CAUSE <b>Acute myocardial infarction</b> <b>2 days</b> DUE TO, OR AS A CONSEQUENCE OF: <b>anterior wall of left ventricle</b></p> <p>(B) <b>Coronary arteriosclerosis</b> <b>years</b> DUE TO, OR AS A CONSEQUENCE OF:</p> <p>(C) <b>Arteriosclerotic Heart Disease</b> <b>years</b></p> <p>II</p> <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>Pulmonary edema</b> <b>days</b></p>					
<p>19A. DATE OF OPERATION <b>2</b></p>		<p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</p>		<p>20A. AUTOPSY? (Yes or No) <b>Yes</b></p>	
<p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If medical examiner)</p>		<p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>		<p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p>	
<p>21D. TIME OF INJURY (APPROX.)</p>		<p>21E. INJURY OCCURRED</p> <p>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>		<p>21F. HOW DID INJURY OCCUR</p>	
<p>22. I certify that (I) (this hospital) attended the deceased from <b>12-1-1969</b> to <b>12-16-1969</b> that (I) (we) last saw the deceased alive on <b>12-16-1969</b> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) <b>(did)</b> (did not) view the body after death.</p>					
<p>23A. SIGNATURE <b>Y. Vouquattun</b></p>		<p>23B. DATE SIGNED <b>12-16-69</b></p>		<p>Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/></p>	
<p>23C. PHYSICIAN'S NAME (Type)</p>		<p>23D. ADDRESS</p>			
<p>24A. BURIAL CREMATION, REMOVAL (Specify)</p>		<p>24B. DATE <b>12-19-69</b></p>		<p>24C. NAME OF CEMETERY OR CREMATORY <b>Lorraine Cemetery</b></p>	
<p>24D. LOCATION (City, town, or county) <b>Baltimore, Maryland</b></p>		<p>25A. DATE REC'D BY HEALTH DEPT. <b>DEC 19 1969</b></p>			
<p>25B. NAME OF REGISTRAR <b>Robert E. Taylor, M.D.</b></p>		<p>25C. FUNERAL DIRECTOR <b>Armatost Funeral Chapel-4600 Liberty Hts</b></p>			



# FUNERAL DIRECTOR: IMPORTANT

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H-652		69 12510		BALTIMORE CITY HEALTH DEPARTMENT		X REG. NO.		69 12510	
BIRTH NO.				2. DATE AND HOUR OF DEATH					
1. NAME OF DECEASED (Type or Print) HARVEY HARRINGTON JR.				12-15-69					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION 33 JOHNS HOPKINS HOSPITAL.				A. STATE MARYLAND B. COUNTY Frederick Co. 6011					
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				C. CITY OR TOWN FREDERICK D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
				E. STREET AND NUMBER 229 S. MARKET ST.					
5. SEX MALE		6. RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 08-29-08		9. AGE (in years lost birthday) 61	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Self - employed		10B. KIND OF BUSINESS OR INDUSTRY Distributor		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME HARVEY A. Harrington, Sr.				14. MOTHER'S MAIDEN NAME LELIA Mateny					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Mrs. Ruth Harrington, 229 S. Market St. Fred. Md.			
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last, II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Ca of large bowel → liver				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Bipartite arrest Liver failure Mild state Ca				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 mo 6 mo	
19A. DATE OF OPERATION 11-2-69		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED obstruction		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from 12-5-1969 to 12-15-1969 that (II) (we) last saw the deceased alive on 12-15-1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE H. J. Fee MD				DEGREE		23B. DATE SIGNED 12/15/69			
23C. PHYSICIAN'S NAME (Type) H. J. Fee MD				DEGREE		23D. ADDRESS Reed Hall, Baltimore			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/19/69		24C. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery		24D. LOCATION (City, town, or county) (State) Frederick Frederick Maryland			
25A. DATE REC'D BY HEALTH DEPT. DEC 19 1969		25B. NAME OF REGISTRAR E. J. Taylor		25C. FUNERAL DIRECTOR Douglas M. Fisher & Son, Frederick, Maryland					

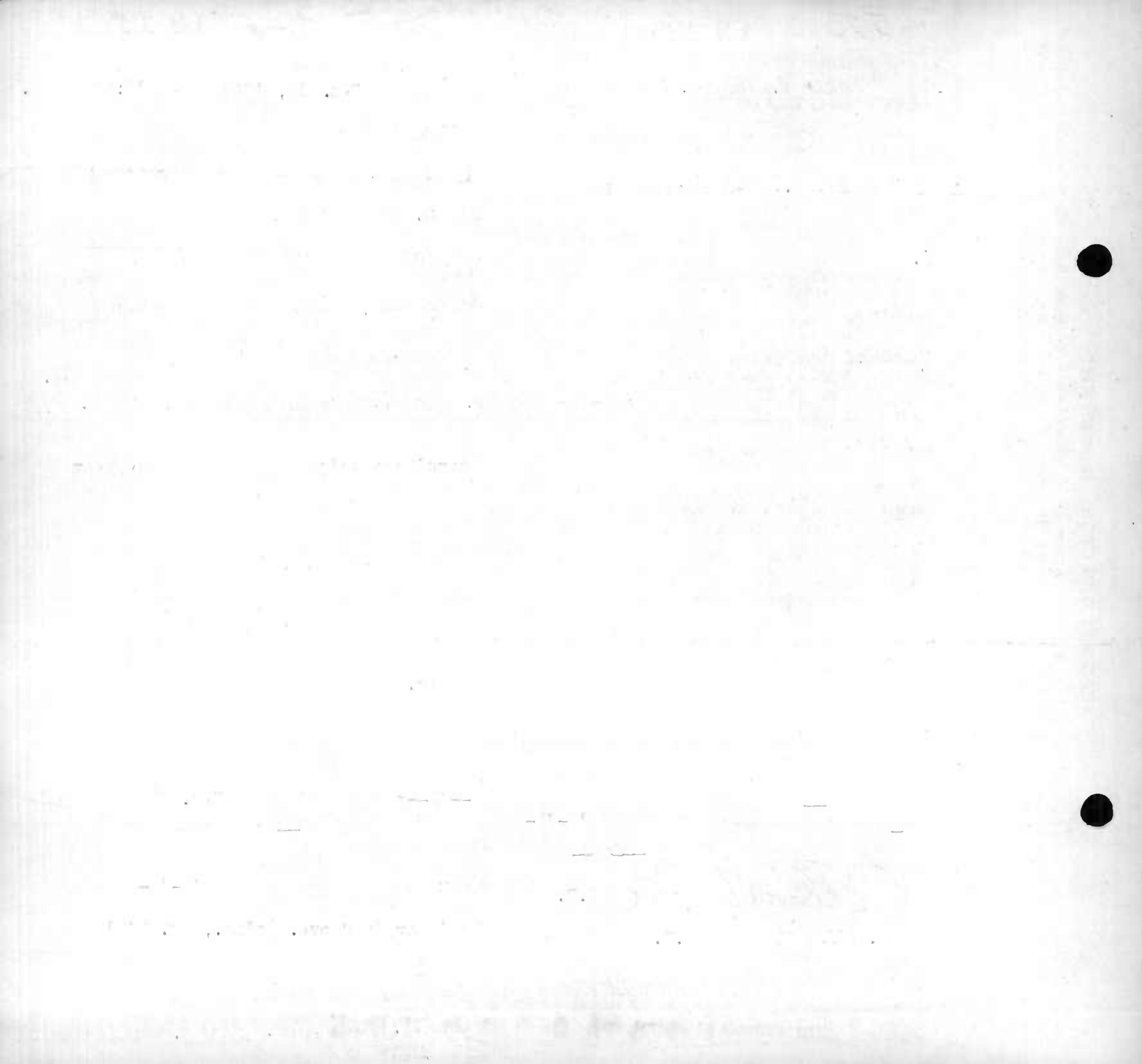




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

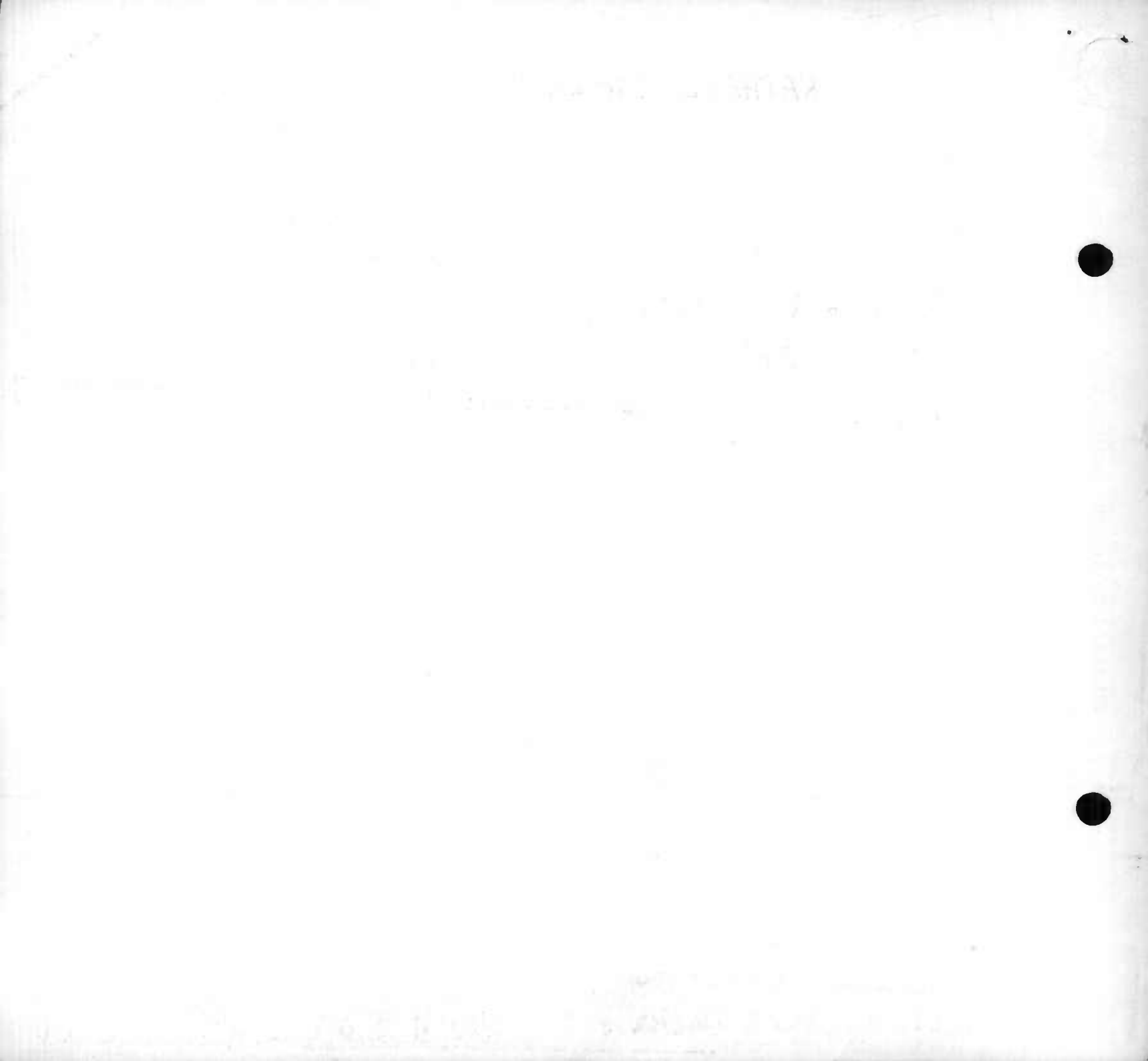
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <b>69 12511</b>	
<div style="display: flex; justify-content: space-between;"> <span><b>P-523</b></span> <span><b>69 12511</b></span> <span><b>CERTIFICATE OF DEATH</b></span> </div>					
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>Katie V. Panegotoplous</b>		2. DATE AND HOUR OF DEATH <b>Dec. 14, 1969</b>   <b>11:20</b> <b>A.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION <b>00 219 W. 29th Street</b>			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>1207</b>		
			C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER <b>219 W. 29th Street</b>		
5. SEX <b>F.</b>	6. RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>9/7/'92</b>	9. AGE (In years lost birthday) <b>77</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Waitress</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Hattiesburg, Miss.</b>	
13. FATHER'S NAME <b>"arben Sanderson</b>				14. MOTHER'S MAIDEN NAME <b>Victoria Yahn</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>135-16-3705</b>		17. INFORMANT ADDRESS <b>St.</b> <b>Mr. Eleftherous Panegotoplous 219 W. 29th</b>	
<div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <p>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <b>1538 I</b> (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.)</p> <p>ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p> </div> <div style="width: 45%;"> <p>CAUSE OF DEATH</p> <p>(A) IMMEDIATE CAUSE <b>carcinoma colon</b> DUE TO, OR AS A CONSEQUENCE OF:</p> <p>(B) DUE TO, OR AS A CONSEQUENCE OF:</p> <p>(C) DUE TO, OR AS A CONSEQUENCE OF:</p> <p>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>one year</b></p> </div> </div>					
<p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).</p>					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No.</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
<p>22. I certify that <u>(1)</u> (this hospital) attended the deceased from <b>7-15-69</b> to <b>Dec. 15</b> 19<b>69</b>, that <u>(1)</u> (we) last saw the deceased alive on <b>12-12-</b> 19<b>69</b> and that in <u>(my)</u> (our) opinion death occurred on the date and hour and from the causes stated above. <u>(1)</u> (We) (did) (did not) view the body after death.</p>					
23A. SIGNATURE <b>E. Ellsworth</b> M.D. DEGREE				23B. DATE SIGNED <b>12-16-69</b>	
23C. PHYSICIAN'S NAME (Type) <b>E. ELLSWORTH COOK M.D.</b>				23D. ADDRESS <b>2431 Maryland Ave. Balto., Md. 21218</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12/17/'69</b>		24C. NAME OF CEMETERY or CREMATORY <b>Druid Ridge Cemetery</b>	
				24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 19 1969</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor, Jr.</b>		25C. FUNERAL DIRECTOR <b>John A. Moran, Inc. 3000 E. Baltimore St</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

S-321		69 12512		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		X		REG. NO.		69 12512	
BIRTH NO.													
1. NAME OF DECEASED (Type or Print) <b>RAPHAEL STOKVIS</b>							2. DATE AND HOUR OF DEATH <b>December 15 1969 5:20 a.m.</b>						
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <b>Sinai Hospital of Baltimore</b>							4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Baltimore, Md.</b> B. COUNTY <b>Baltimore</b> C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>6747 Townbrook Dr. #7</b>						
5. SEX <b>male</b>		6. RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>5/3/03</b>		9. AGE (In years last birthday) <b>66</b>		10. Under 1 Yr. Months: Days: If Under 24 Hrs. Min.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Restaurant</b>							10B. KIND OF BUSINESS OR INDUSTRY <b>Owner</b>			11. BIRTHPLACE (State or foreign country) <b>New York</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>Morris Stokvis</b>							14. MOTHER'S MAIDEN NAME <b>Nonie P.</b>						
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>							16. SOCIAL SECURITY NO. <b>067-01-8561</b>		17. INFORMANT <b>MRS. Frances Stokvis</b> ADDRESS <b>6747 TOWNBROOK DR. #07</b>				
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Cardiac Failure</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Low Bowel Obstruction possibly cancer</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH													
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).													
19A. DATE OF OPERATION <b>2</b>				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20A. AUTOPSY? (Yes or No) <b>Yes</b>				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, locality, street, office bldg., etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?					
22. I certify that <del>if</del> (this hospital) attended the deceased from <b>Dec. 14</b> 19 <b>69</b> to <b>Dec. 15</b> 19 <b>69</b> that <del>if</del> (we) last saw the deceased alive on <b>Dec. 15</b> 19 <b>69</b> and that <del>in</del> (my) (our) opinion death occurred on the date and hour and from the causes stated above. <del>if</del> (We) (did) (did not) view the body after death.													
23A. SIGNATURE <b>Kantorn</b>							23B. DATE SIGNED			23C. PHYSICIAN'S NAME (Type) <b>KANTORN KRITAYAKIRANA</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>							24B. DATE <b>12-17-69</b>		24C. NAME OF CEMETERY or CREMATORY <b>Baltimore Hebrew</b>			24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 19 1969</b>							25B. NAME OF REGISTRAR <b>Robert E. Taylor, M.D.</b>			25C. FUNERAL DIRECTOR <b>John J. Leonard</b> ADDRESS <b>6016 Bristow Rd.</b>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<div style="display: flex; justify-content: space-between;"> <span><b>G-460</b></span> <span><b>69 12513</b></span> <span><b>BALTIMORE CITY HEALTH DEPARTMENT</b></span> </div> <div style="display: flex; justify-content: space-between;"> <span><b>CERTIFICATE OF DEATH</b></span> <span><b>REG. NO. 69 12513</b></span> </div>					
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>GALLERY, Delma C.</b>		2. DATE AND HOUR OF DEATH <b>Dec. 15, 1969 1 3:35 P.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>2734</b>		C. CITY OR TOWN <b>Baltimore</b>	
FULL NAME OF HOSPITAL OR INSTITUTION <b>90 Bolton Hill Nursing &amp; Convalescent Ctr.</b>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <b>FEMALE</b>	6. RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7-14-94</b>	9. AGE (In years last birthday) <b>75</b>	If Under 1 Yr. Months Days if Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED SALES LADY</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>HUTZLERS DEPARTMENT STORE</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>Robert Gallery</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>212-18-9336</b>		17. INFORMANT <b>FAMILY</b>	
18. <b>5-99.0 I</b>		CAUSE OF DEATH		ADDRESS <b>SAMIE</b>	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Pneumonia</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>few days</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <b>arteriosclerotic heart disease</b> DUE TO, OR AS A CONSEQUENCE OF: <b>years</b>			
(C) <b>chronic urinary tract infection</b> DUE TO, OR AS A CONSEQUENCE OF: <b>years</b>					
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>9/12 1968</b> to <b>12/15 1969</b> , that (I) (we) last saw the deceased alive on <b>12/15 1969</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>ALLAN H. MAECHT MD</b>		Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <b>12/16/69</b>	
23C. PHYSICIAN'S NAME (Type) <b>ALLAN H. MAECHT MD</b>		23D. ADDRESS <b>2 E Red St BALTIMORE</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>12-18-69</b>		24C. NAME OF CEMETERY or CREMATORY <b>WESTERN CEMETERY</b>	
24D. LOCATION <b>BALTO., MD.</b>		24E. NAME OF REGISTRAR <b>Robert E. Fisher, M.D.</b>		24F. FUNERAL DIRECTOR <b>Sp. Helms</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 19 1969</b>		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR <b>Conklin 5444 BELAIR Rd.</b>	

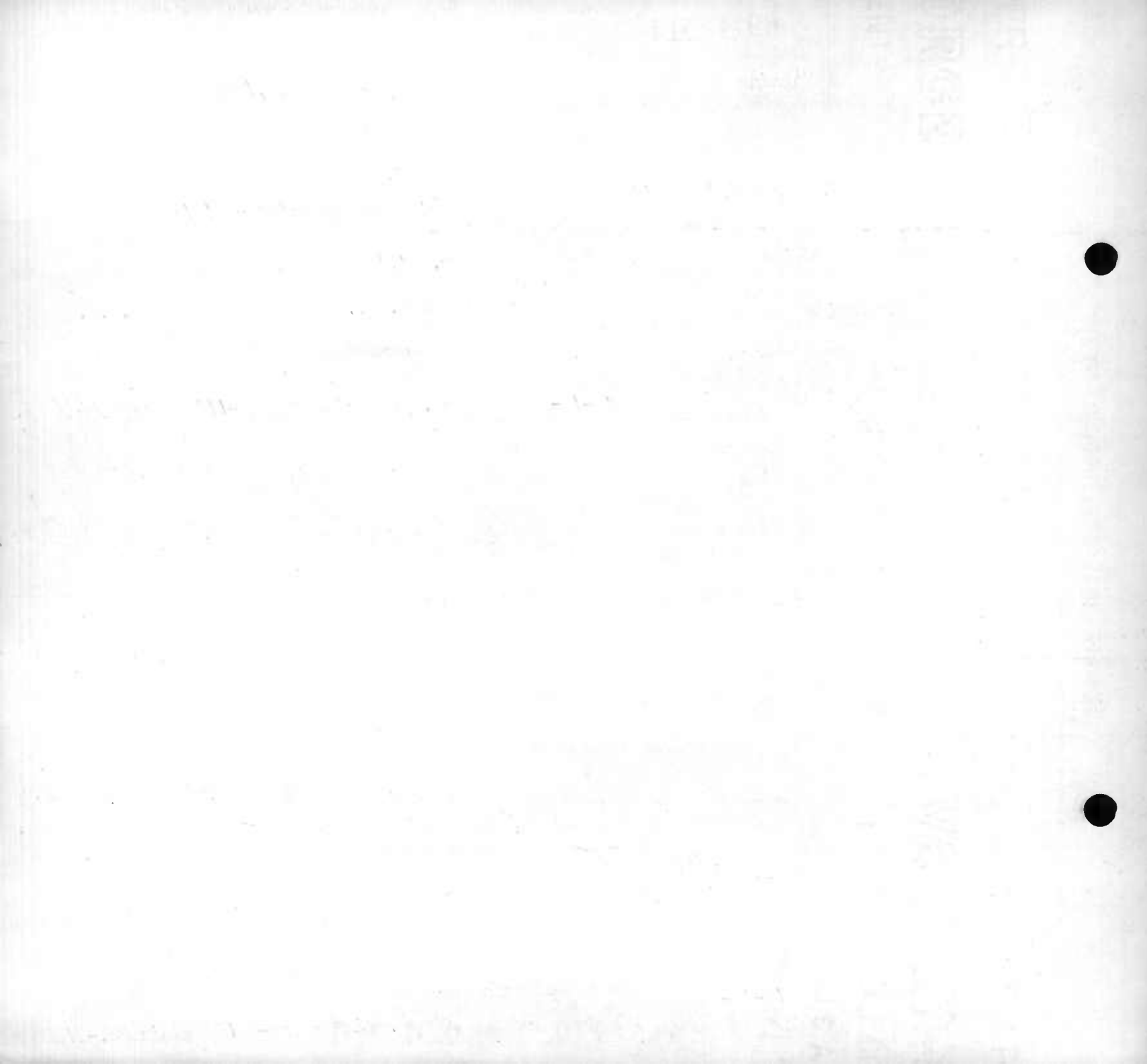




# FUNERAL DIRECTOR: IMPORTANT

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A-000 69 12514				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 69 12514	
1. NAME OF DECEASED (Type or Print) <i>Katherine May Ay</i>				2. DATE AND HOUR OF DEATH <i>December 14, 1969</i>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>44 Union Memorial Hospital</i>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>2633</i>			
5. SEX <i>Female</i>		6. RACE <i>White</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Dec. 31, 1886</i>	
9. AGE (In years last birthday) <i>82</i>		10. UNDER 1 Yr. Months: Days: Hours: Min.		11. BIRTHPLACE (State or foreign country) <i>Balto. Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>				10B. KIND OF BUSINESS OR INDUSTRY			
13. FATHER'S NAME <i>John Ackerman</i>				14. MOTHER'S MAIDEN NAME <i>Katherine Kuntmiller</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>				16. SOCIAL SECURITY NO. <i>219-10-8825</i>		17. INFORMANT <i>Mrs. Catherine Goller-1110 Sleepy Dell Ct.</i>	
18. <i>410.9 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Coronary Thrombosis -</i> (B) <i>Arteriosclerotic Cardiovascular Disease</i> DUE TO, OR AS A CONSEQUENCE OF: (C) _____			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) ( <del>the hospital</del> ) attended the deceased from <i>8/29</i> 19 <i>53</i> to <i>Dec 14</i> 19 <i>69</i> . that (I) ( <del>was</del> ) last saw the deceased alive on <i>11/19</i> 19 <i>69</i> and that in ( <del>my</del> ) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>was</del> ) ( <del>did</del> ) (did not) view the body after death.							
23A. SIGNATURE <i>[Signature]</i>				23B. DATE SIGNED			
23C. PHYSICIAN'S NAME (Type) <i>[Signature]</i>				23D. ADDRESS			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>12-17-69</i>		24C. NAME OF CEMETERY or CREMATORY <i>Immanuel Lutheran Cemetery</i>		24D. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>DEC 19 1969</i>		25B. NAME OF REGISTRAR <i>Robert E. Fisher, M.D.</i>		25C. FUNERAL DIRECTOR <i>John C. Wilder Inc</i>		25D. ADDRESS <i>6415 Belair Rd. - 21206</i>	



# FUNERAL DIRECTOR: IMPORTANT

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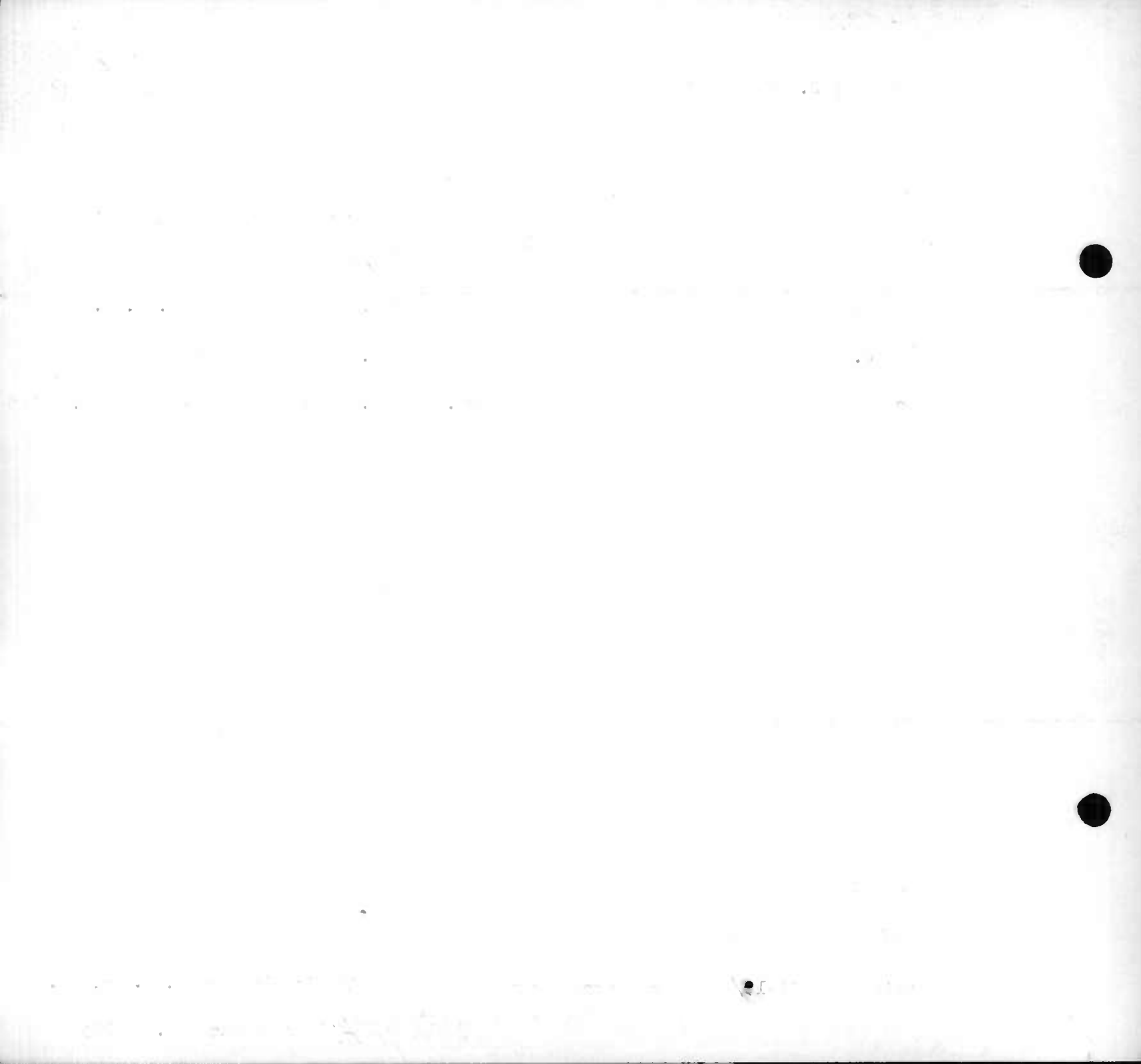
<div style="display: flex; justify-content: space-between;"> <span><b>K-242</b></span> <span><b>69 12515</b></span> <span><b>BALTIMORE CITY HEALTH DEPARTMENT</b></span> </div>		<b>CERTIFICATE OF DEATH</b>		<b>REG. NO. 69 12515</b>	
<b>BIRTH NO.</b> 1. NAME OF DECEASED (Type or Print) <b>MR AUGUST KAZLAUSKI JR.</b>		<b>2. DATE AND HOUR OF DEATH</b> <b>17 Dec. 1969 2-30 AM.</b>			
<b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b> FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>48 Maryland Gen. Hospital.</b>		<b>4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)</b> A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b> <b>1902</b> C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>1327 W. Lombard St.</b>			
<b>5. SEX</b> <b>Male</b>	<b>6. RACE</b> <b>White</b>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>9/21/1915</b>	<b>9. AGE (In years last birthday)</b> <b>54</b>	<b>10. IF Under 1 Yr. Months: Days: Hours: Min.</b>
<b>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)</b> <b>Tool grinder</b>		<b>10B. KIND OF BUSINESS OR INDUSTRY</b> <b>Marquette Co.</b>		<b>11. BIRTHPLACE (State or foreign country)</b> <b>W. Virginia</b>	
<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A</b>		<b>13. FATHER'S NAME</b> <b>August Kazlauski</b>			
<b>14. MOTHER'S MAIDEN NAME</b> <b>Ysabela Martinikus</b>		<b>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)</b> <b>No</b>			
<b>16. SOCIAL SECURITY NO.</b> <b>212-01-1780</b>		<b>17. INFORMANT</b> <b>Helen Kazlauski - 1327 W. Lombard St.</b>			
<b>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>162.1 I</b> <b>Cerebral Malignancy</b>		<b>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:</b> <b>2 weeks.</b>		<b>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</b>	
<b>19. ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>(B) Bronchogenic Carcinoma.</b>		<b>(B) DUE TO, OR AS A CONSEQUENCE OF:</b>			
<b>(C) DUE TO, OR AS A CONSEQUENCE OF:</b>					
<b>II</b> <b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</b>					
<b>19A. DATE OF OPERATION</b> <b>12/15/69</b>		<b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b> <b>No</b>		<b>20A. AUTOPSY? (Yes or No)</b> <b>No</b>	
<b>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</b>					
<b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (Indify medical examined) <input type="checkbox"/>		<b>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</b>		<b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)	
<b>21D. TIME OF INJURY (APPROX.)</b> (Month) (Day) (Year) (Hour)		<b>21E. INJURY OCCURRED</b> White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>		<b>21F. HOW DID INJURY OCCUR?</b>	
<b>22. I certify that (I) (this hospital) attended the deceased from 12/15/1969 to 12/17/1969 that (I) (we) last saw the deceased alive on 12/16/1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.</b>					
<b>23A. SIGNATURE</b> <b>Mohammed S Al-Israhim</b>		<b>Attending Phys.</b> <input type="checkbox"/> <b>Med. Director</b> <input type="checkbox"/> <b>Staff Phys.</b> <input checked="" type="checkbox"/>		<b>23B. DATE SIGNED</b> <b>12/17/1969</b>	
<b>23C. PHYSICIAN'S NAME (Type)</b> <b>M. S. AL-ISRAHIM M.D.</b>		<b>23D. ADDRESS</b> <b>Maryland Gen Hospital.</b>			
<b>24A. BURIAL CREMATION, REMOVAL (Specify)</b> <b>Burial</b>	<b>24B. DATE</b> <b>12/20/69</b>	<b>24C. NAME OF CEMETERY OR CREMATORY</b> <b>Moreland Park Cemetery</b>		<b>24D. LOCATION (City, town, or county) (State)</b> <b>Baltimore Md.</b>	
<b>25A. DATE REC'D BY HEALTH DEPT.</b> <b>DEC 19 1969</b>		<b>25B. NAME OF REGISTRAR</b> <b>Robert E. Jansen, M.D.</b>		<b>25C. FUNERAL DIRECTOR</b> <b>John J. Curran &amp; Son</b>	
<b>VS 150-REV. 1/1/68</b>					



# FUNERAL DIRECTOR: IMPORTANT

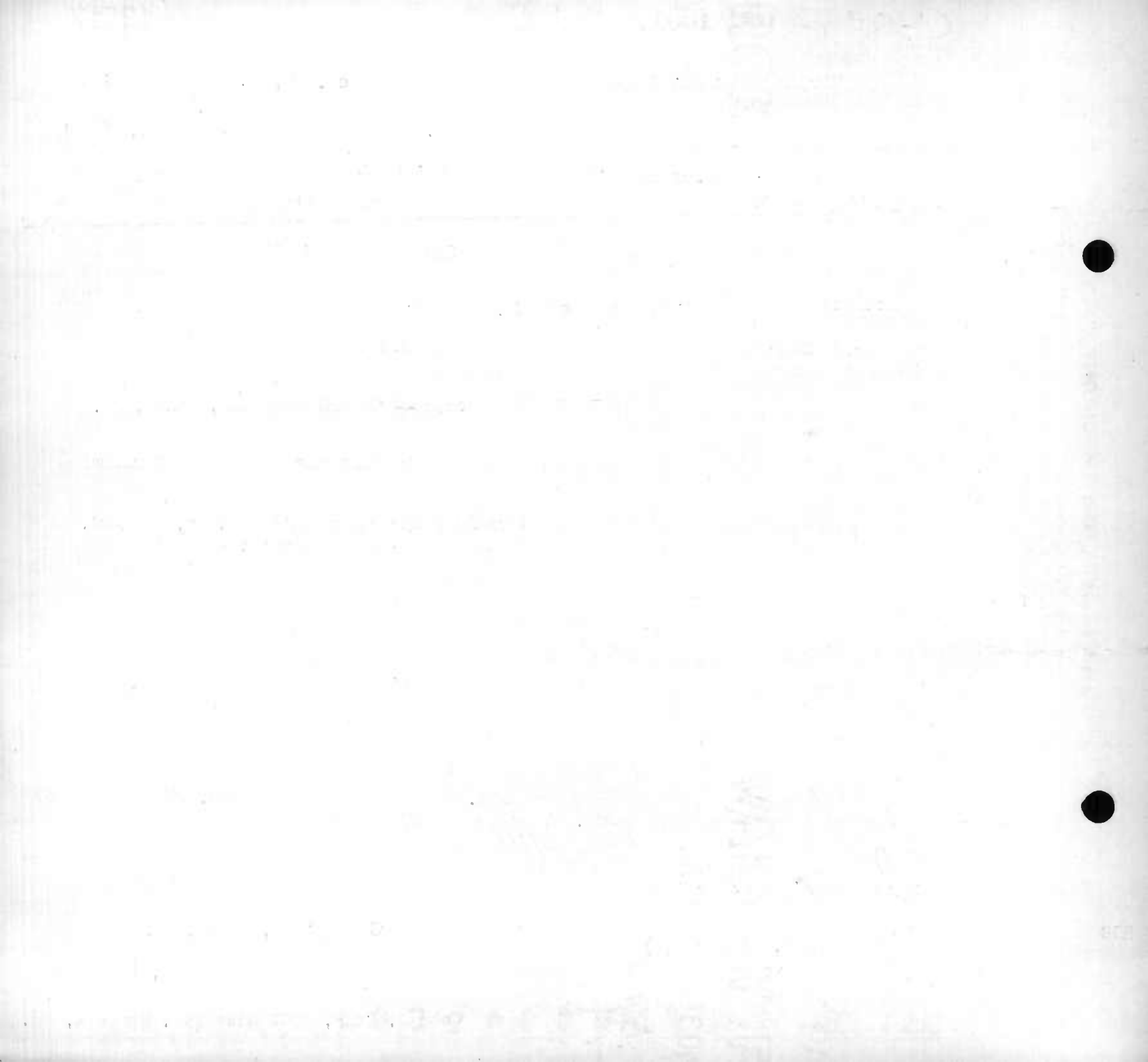
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>69 12516</u>	
<div style="display: flex; justify-content: space-between;"> <span><b>S-536</b></span> <span><b>69 12516</b></span> <span><b>CERTIFICATE OF DEATH</b></span> </div>					
BIRTH NO. <u>44-08643</u>					
1. NAME OF DECEASED (Type or Print) <b>DENISE C. SCHNEIDER</b>			2. DATE AND HOUR OF DEATH <b>12-16-69 14:30 P.M.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>MERCY HOSPITAL, INC. BALTO. MD.</b>			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>2544</b>		
			C. CITY OR TOWN <b>BALTIMORE</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER <b>607 Jeffney St. BALT. 21225</b>		
5. SEX <b>F</b>	6. RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>3-26-1964</b>	9. AGE (In years last birthday) <b>5 yrs.</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Student</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>	12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>
13. FATHER'S NAME <b>EARL J. SCHNEIDER</b>			14. MOTHER'S MAIDEN NAME <b>HAZEL W. SCHNEIDER (Wicklein)</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <b>Mrs. Earl J. Schneider 607 Jeffney St. 21225</b>	
18. <b>20501</b> CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE <b>ACUTE GRANULOCYTIC LEUKEMIA</b> DUE TO, OR AS A CONSEQUENCE OF:  (B) _____ DUE TO, OR AS A CONSEQUENCE OF:  (C) _____	
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 weeks</b>					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>12-12</b> 19 <b>69</b> to <b>12-16</b> 19 <b>69</b> that (I) (we) lost saw the deceased alive on <b>12-16</b> 19 <b>69</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Dante P. Gabriel, M.D.</b>				23B. DATE SIGNED <b>12-16-69</b>	
23C. PHYSICIAN'S NAME (Type) <b>DANTE P. GABRIEL, M.D.</b>				23D. ADDRESS <b>MERCY HOSPITAL, INC. BALTO. MD.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12/19/69</b>		24C. NAME OF CEMETERY or CREMATORY <b>Holy Cross Cemetery</b>	
24D. LOCATION (City, town, or county) (State) <b>Ritchie Highway A. A. Co. Md.</b>					
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 19 1969</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor, M.D.</b>		25C. FUNERAL DIRECTOR <b>McGee F. H.</b>	
				ADDRESS <b>237 Patapsco Ave. 21225</b>	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

C-513		69 12517		BALTIMORE CITY HEALTH DEPARTMENT		X		REG. NO. 69 12517	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>Virginus Wright Compton</b>				2. DATE AND HOUR OF DEATH <b>Dec. 17, 1969</b>		7: 40 A M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>Baltimore</b>					
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>US Public Health Service Hospital 3100 Wyman Parkway</b>				C. CITY OR TOWN <b>Essex Baltimore</b>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
				E. STREET AND NUMBER <b>610 Almond Avenue</b>					
5. SEX <b>Male</b>	6. RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>1/20/09</b>		9. AGE (In years last birthday) <b>60</b>		If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>				10B. KIND OF BUSINESS OR INDUSTRY <b>Bethlehem Steel Co.</b>		11. BIRTHPLACE (State or foreign country) <b>Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Emmit Compton</b>				14. MOTHER'S MAIDEN NAME <b>Bessie ?</b>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>213-07-9921</b>		17. INFORMANT ADDRESS <b>Records- US PHS Hospital, Balto, Md.</b>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <b>3719.21</b> (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Cor Pulmonale</b> <b>Terminal</b>				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) CHRONIC obstructive lung disease, 9 yrs. severe (C)					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).									
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?		(If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <b>Nov. 5</b> 19 <b>69</b> to <b>Dec. 17</b> 19 <b>69</b> , that (I) (we) last saw the deceased alive on <b>Dec. 17</b> 19 <b>69</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <i>Irving Wolfe</i>				23B. DATE SIGNED <b>12/17/69</b>		23C. PHYSICIAN'S NAME (Type) <b>Irving Wolfe, SA Surg (R)</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12/20/69</b>		24C. NAME OF CEMETERY or CREMATORY <b>Oak Lawn Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 19 1969</b>		25B. NAME OF REGISTRAR <b>Robert E. Fisher, M.D.</b>		25C. FUNERAL DIRECTOR <b>John S. J. Ouda</b>		ADDRESS <b>7922 Wise Ave. Dundalk, Md.</b>			

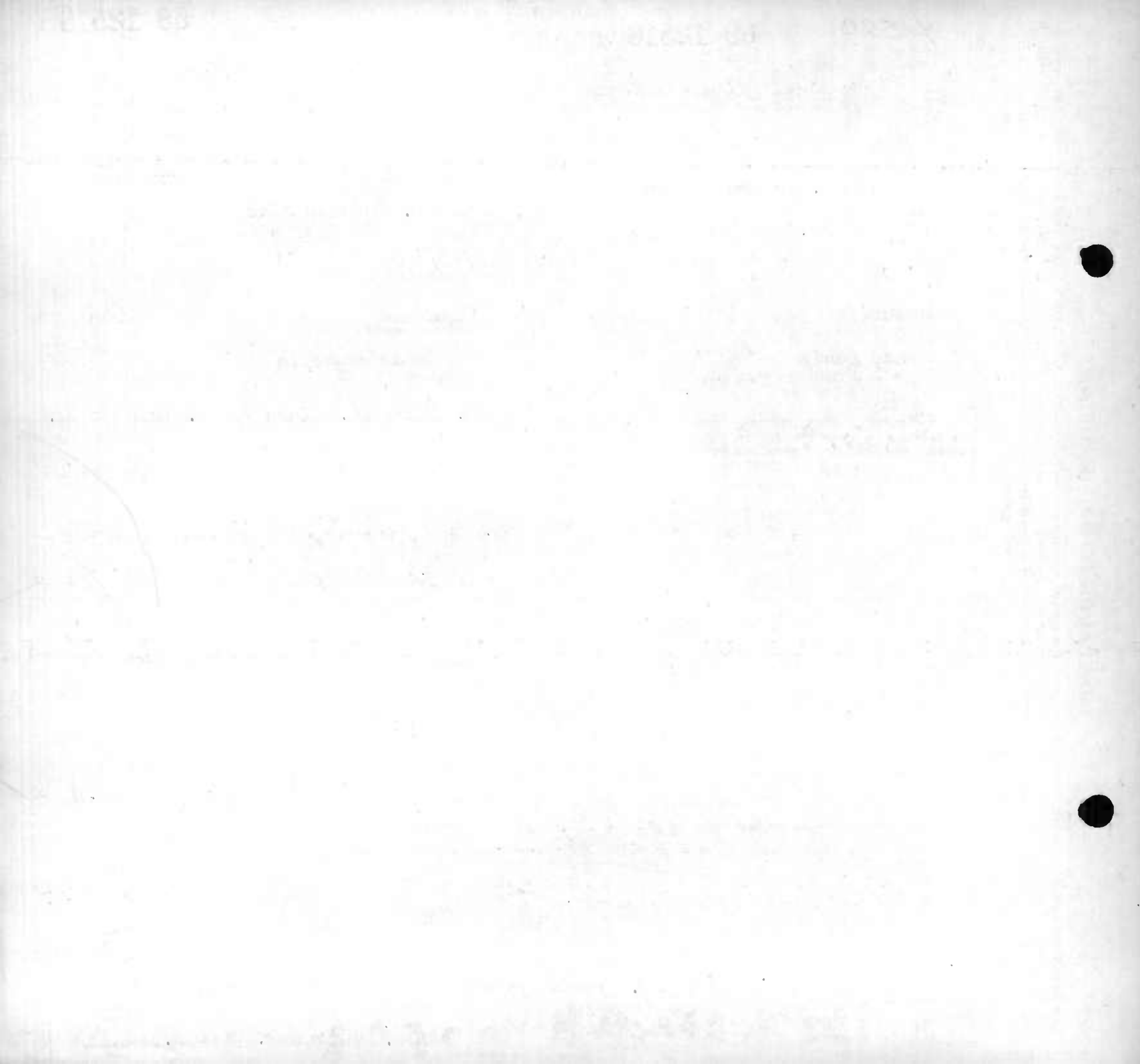




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

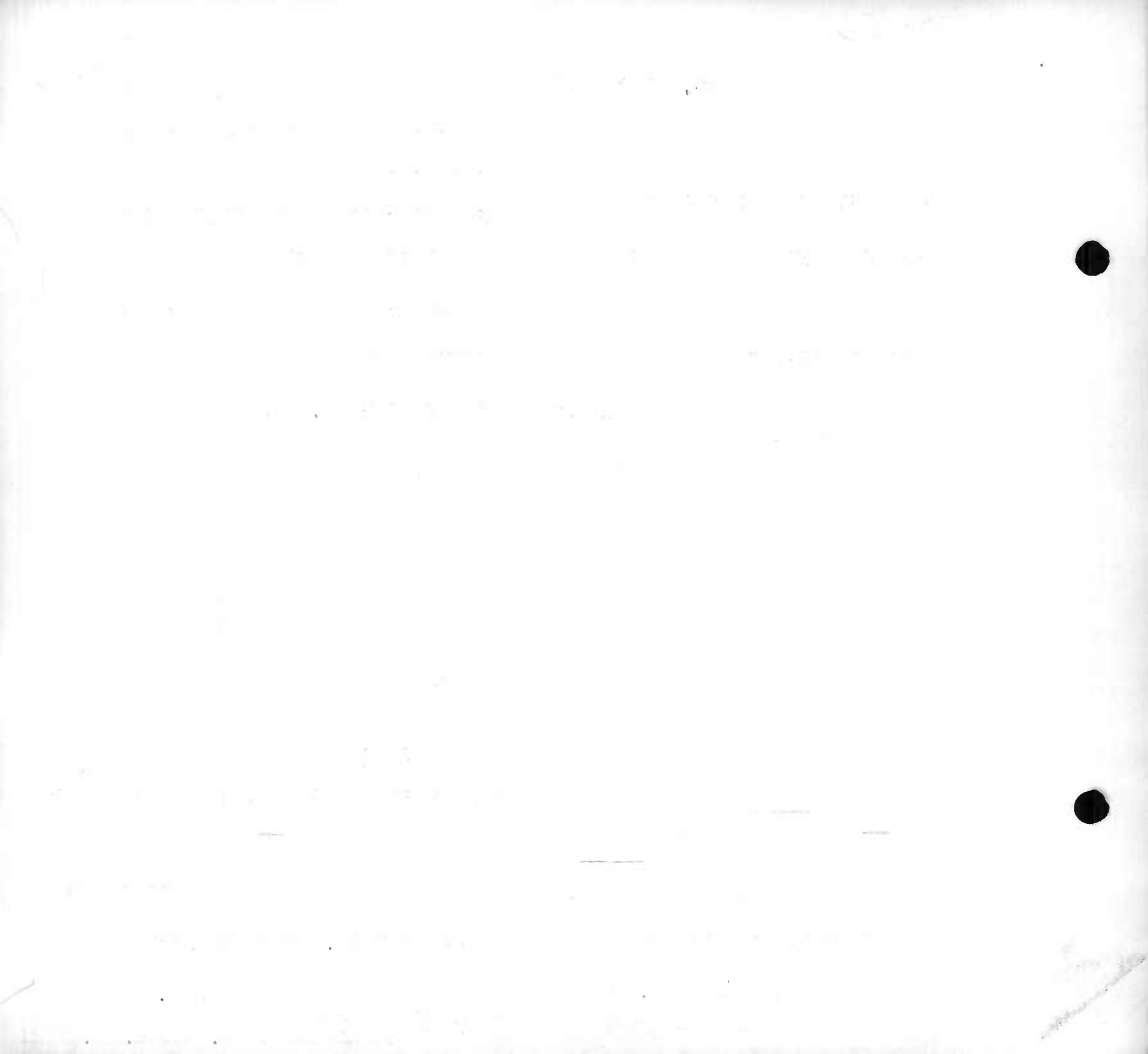
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 69 12518	
H-520		69 12518		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <i>Margaret Elizabeth Hines</i>		2. DATE AND HOUR OF DEATH <i>12-4-69</i>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>124 N. Potomac Street</i>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>601</i> C. CITY OR TOWN <i>Baltimore</i> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <i>124 N. Potomac Street</i>			
5. SEX <i>F.</i>	6. RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>2/12/'90</i>	9. AGE (In years last birthday) <i>79</i>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	
13. FATHER'S NAME <i>Henry Lentz</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service <i>No</i>		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Mr. Harry C. Hines 124 N. Potomac St.</i>	
18. <i>250.91</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF <i>Coronary Occlusion Sudden</i> (B) <i>Coronary Artery Disease 10 yrs</i> (C) <i>Diabetes mellitus 10 yrs</i>			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>June 19 58</i> to <i>December 4 69</i> , that (I) (we) last saw the deceased alive on <i>3/28 19 69</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Charles Chomell</i>				23B. DATE SIGNED <i>12/4/69</i>	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>12/6/'69</i>		24C. NAME of CEMETERY or CREMATORY <i>Mt. Carmel Cemetery</i>	
24D. LOCATION <i>Baltimore, Maryland</i>		24E. LOCATION (City, town, or county) (State)			
25A. DATE REC'D BY HEALTH DEPT. <i>DEC 19 1969</i>		25B. NAME OF REGISTRAR <i>Robert E. Taylor, M.D.</i>		25C. FUNERAL DIRECTOR <i>John A. Moran, Inc.</i>	
				ADDRESS <i>3000 E. Baltimore St</i>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

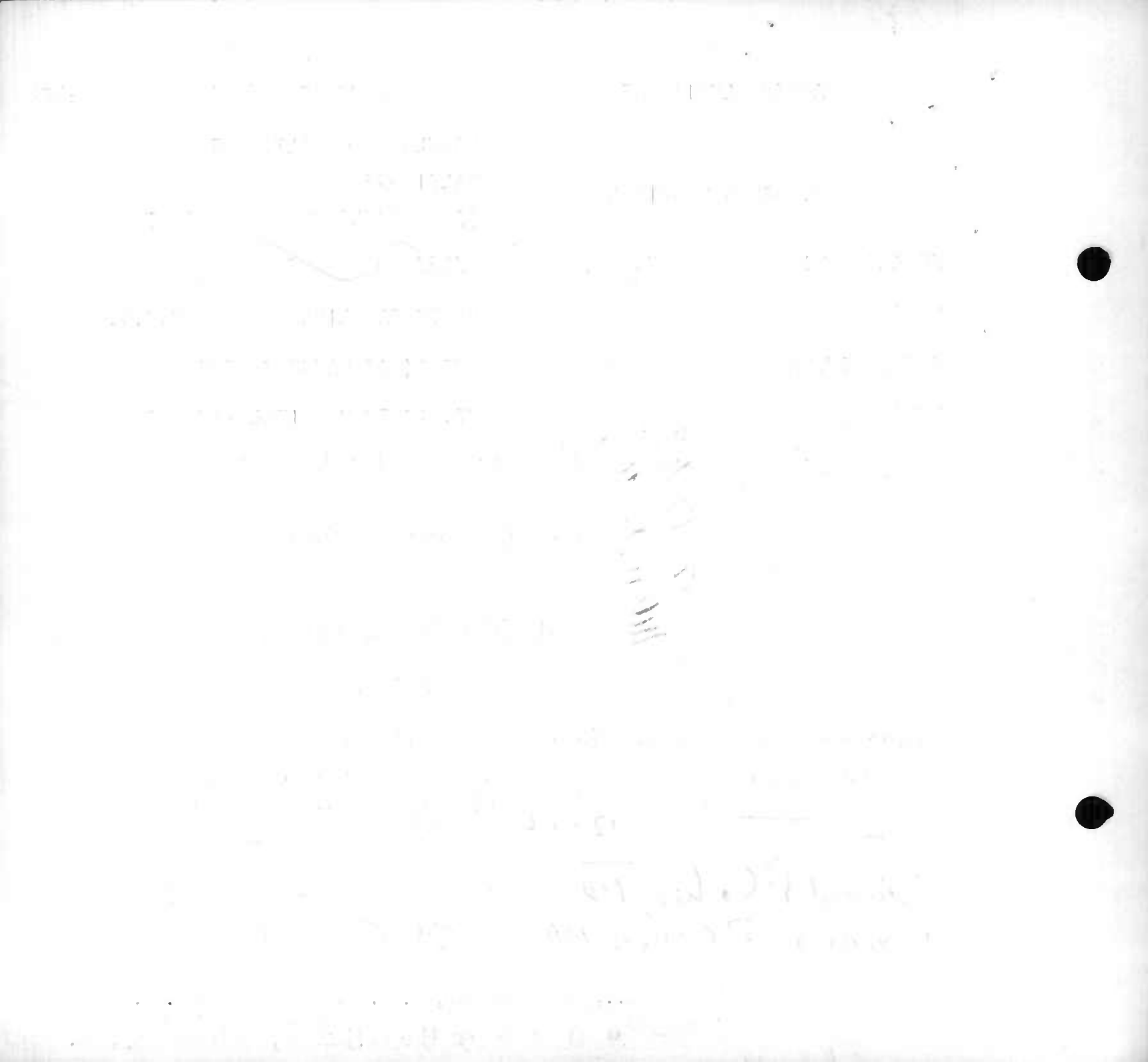
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>69 12519</u>
<b>3-516</b> <b>69 12519</b> <b>CERTIFICATE OF DEATH</b>		<b>69 12519</b>		
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH		
SANFORD, ALMA PETERS		12/17/69 4:32 P.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION  40 ST AGNES HOSPITAL		A. STATE MARYLAND		
		B. COUNTY BALTIMORE COUNTY 5300		
16. SOCIAL SECURITY NO.  219-20-7145		C. CITY OR TOWN CATONSVILLE		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
		E. STREET AND NUMBER FOREST ROAD AT 800 HILTON AVE		
5. SEX FEMALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 08 04 15	9. AGE (In years lost birthday) 54
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND
13. FATHER'S NAME BENJAMIN PETERS		14. MOTHER'S MAIDEN NAME ESTHER DYKES		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		17. INFORMANT ST AGNES HOSP. RECORDS		
16. SOCIAL SECURITY NO. 219-20-7145		ADDRESS		
18. <u>239.0 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE Tumor of pharynx DUE TO, OR AS A CONSEQUENCE OF:  (B) _____ DUE TO, OR AS A CONSEQUENCE OF:  (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). Anoxia secondary to tumor airway obstruction				
19A. DATE OF OPERATION D	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) NO	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, locality, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from <u>DECEMBER 13</u> 19 <u>69</u> to <u>DECEMBER 17</u> 19 <u>69</u> that (I) (we) lost saw the deceased alive on <u>12/17</u> 19 <u>69</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <i>Bernhard Laukenmann</i>		23B. DATE SIGNED 12 17 69		
23C. PHYSICIAN'S NAME (Type) BERNHARD LAUKENMANN		23D. ADDRESS ST AGNES HOSP. BALTO MD 21229		
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE 12/18/69	24C. NAME of CEMETERY or CREMATORY St. Johns	24D. LOCATION (City, town, or county)	(State)
25A. DATE REC'D BY HEALTH DEPT. DEC 19 1969	25B. NAME OF REGISTRAR Robert E. Fisher, M.D.	25C. FUNERAL DIRECTOR Wittke Funeral Home	ADDRESS 1630 Edmondson Ave. Balto. Md. 21228	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 69 12520	
P-626 69 12520		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <b>PARKER, LYDIA MAE</b>		2. DATE AND HOUR OF DEATH <b>DECEMBER 16, 1969 9:45A.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>ST. AGNES HOSPITAL</b>		4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTIMORE</b> C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER <b>7300 CASTLE MOOR RD 21207</b>	
5. SEX <b>FEMALE</b>	6. RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>04/16/84</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>NONE</b>		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <b>85</b>
11. BIRTHPLACE (State or foreign country) <b>NORTH CAROLINA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>JASON DEYTON</b>		14. MOTHER'S MAIDEN NAME <b>BUENA (NEE MASTERS) DEYTON</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) <b>NONE</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>ST. AGNES HOSPITAL RECORDS</b>		ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>PULMONARY EMBOLUS</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 hr.</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>FX (E) PUBIC RAMUS</b> (B) DUE TO, OR AS A CONSEQUENCE OF: <b>10 DAYS</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I <b>ASCVD - SENILITY</b>		(C) DUE TO, OR AS A CONSEQUENCE OF: <b>5 YRS</b>	
19A. DATE OF OPERATION <b>D</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) <b>NO</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <b>CLEAR BY EXAMINER ON APPEAL</b>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>BEDROOM</b>	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>HOME 5300</b>		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) <b>12-6-69</b>	
21E. INJURY OCCURRED <b>White AI Work <input type="checkbox"/> Not White AI Work <input checked="" type="checkbox"/></b>		21F. HOW DID INJURY OCCUR? <b>SLIPPED IN BED ROOM</b>	
22. I certify that (I) (this hospital) attended the deceased from <b>12-6-69</b> to <b>12-16-69</b> that (I) (we) last saw the deceased alive on <b>12-16-69</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <b>Edward R. Cohen, MD</b>		23B. DATE SIGNED <b>12-16-69</b>	
23C. PHYSICIAN'S NAME (Type) <b>EDWARD R. COHEN, MD</b>		23D. ADDRESS <b>St. Agnes Hosp</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12/19/69</b>	
24C. NAME of CEMETERY or CREMATORY <b>Red Hill, Greenmountain, N. C.</b>		24D. LOCATION (City, town, or county) (State) <b>Greenmountain, N. C.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 19 1969</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor, Jr.</b>	
25C. FUNERAL DIRECTOR <b>Howard County</b>		25D. ADDRESS <b>Home</b>	
25E. NAME OF REGISTRAR <b>Howard County</b>		25F. ADDRESS <b>Howard County</b>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

H-162 69 12521				BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 69 12521	
1. NAME OF DECEASED (Type or Print) <b>Hoffrogge, Christian</b>				2. DATE AND HOUR OF DEATH <b>12/16/69 7:45 P.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>Good Samaritan Hospital</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland 21229</b> B. COUNTY <b>2854</b> C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>412 Old Orchard Rd.</b>			
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1/12/89</b>	9. AGE (In years last birthday) <b>80</b>	If Under 1 Yr. Months: Days: Hours: Min.	If Under 24 Hrs. Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>General Sales Manager, Reliance Co.</b>				10B. KIND OF BUSINESS OR INDUSTRY <b>Bufflo. New York</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. BIRTHPLACE (State or foreign country) <b>Bufflo. New York</b>				14. MOTHER'S MAIDEN NAME <b>Louise Dill</b>			
13. FATHER'S NAME <b>Christian H. Hoffrogge</b>				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>			
16. SOCIAL SECURITY NO. <b>212095766A</b>				17. INFORMANT <b>Clyde H. Baden Jr. Brandywine</b>			
18. <b>412.4 I</b> DISEASE OF CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>ASCVD</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Myxedema</b> 3 mo.				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>ASCVD</b> (B) DUE TO, OR AS A CONSEQUENCE OF: <b>Myxedema</b> (C) _____			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <b>D</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>12/16</b> 19 <b>69</b> to <b>12/16</b> 19 <b>69</b> , that (I) (we) lost saw the deceased alive on <b>12/16</b> 19 <b>69</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Dudley D. Goulden M.D.</b>				23B. DATE SIGNED <b>12/16/69</b>			
23C. PHYSICIAN'S NAME (Type) <b>Dudley D. Goulden, M.D.</b>				23D. ADDRESS <b>Good Samaritan Hospital</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12/19/69</b>		24C. NAME OF CEMETERY or CREMATORY <b>Lorraine Park Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 19 1969</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR <b>Witzke, Inc. 1630 Edmondson Ave. Catonsville</b>		ADDRESS	

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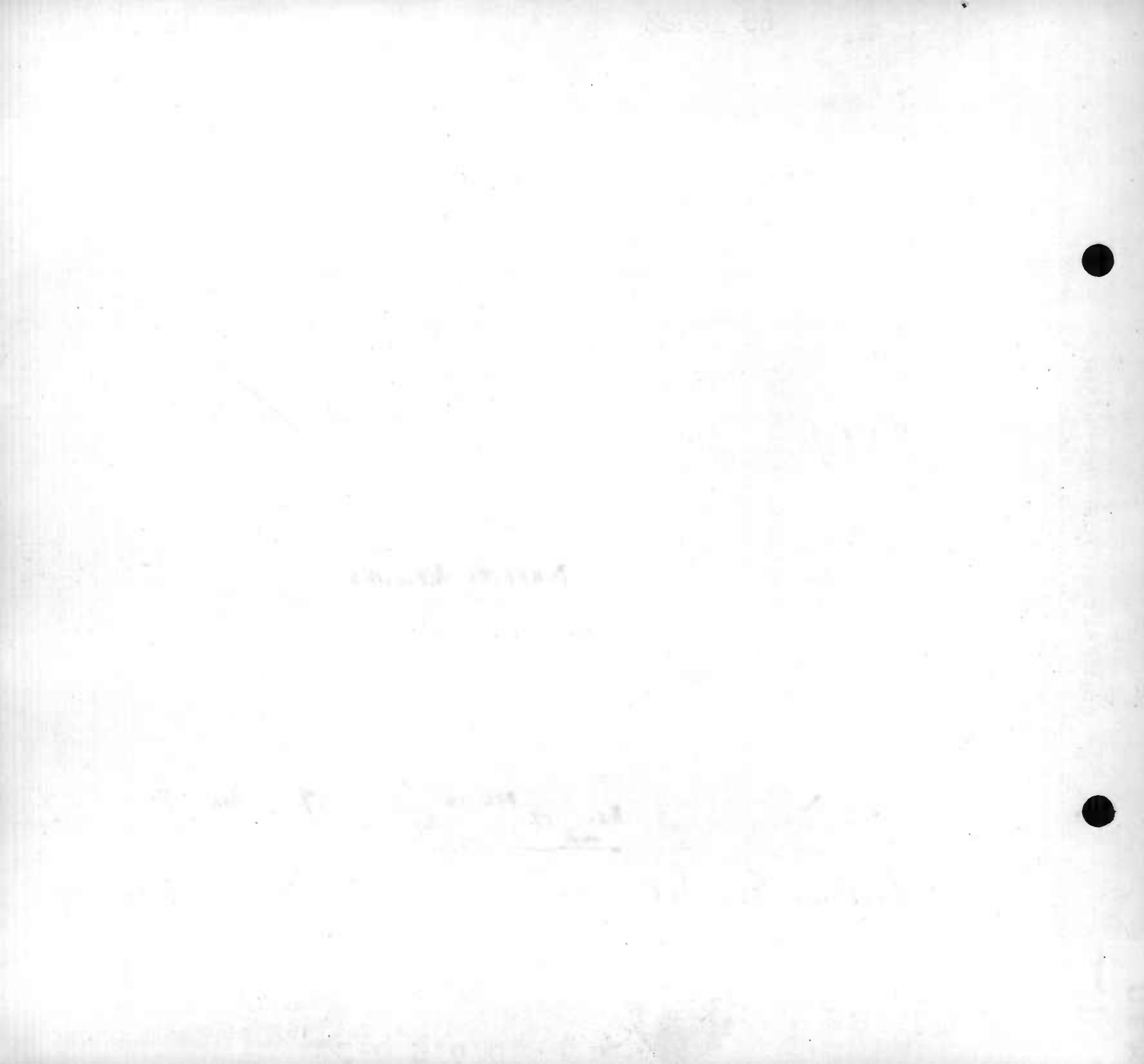
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

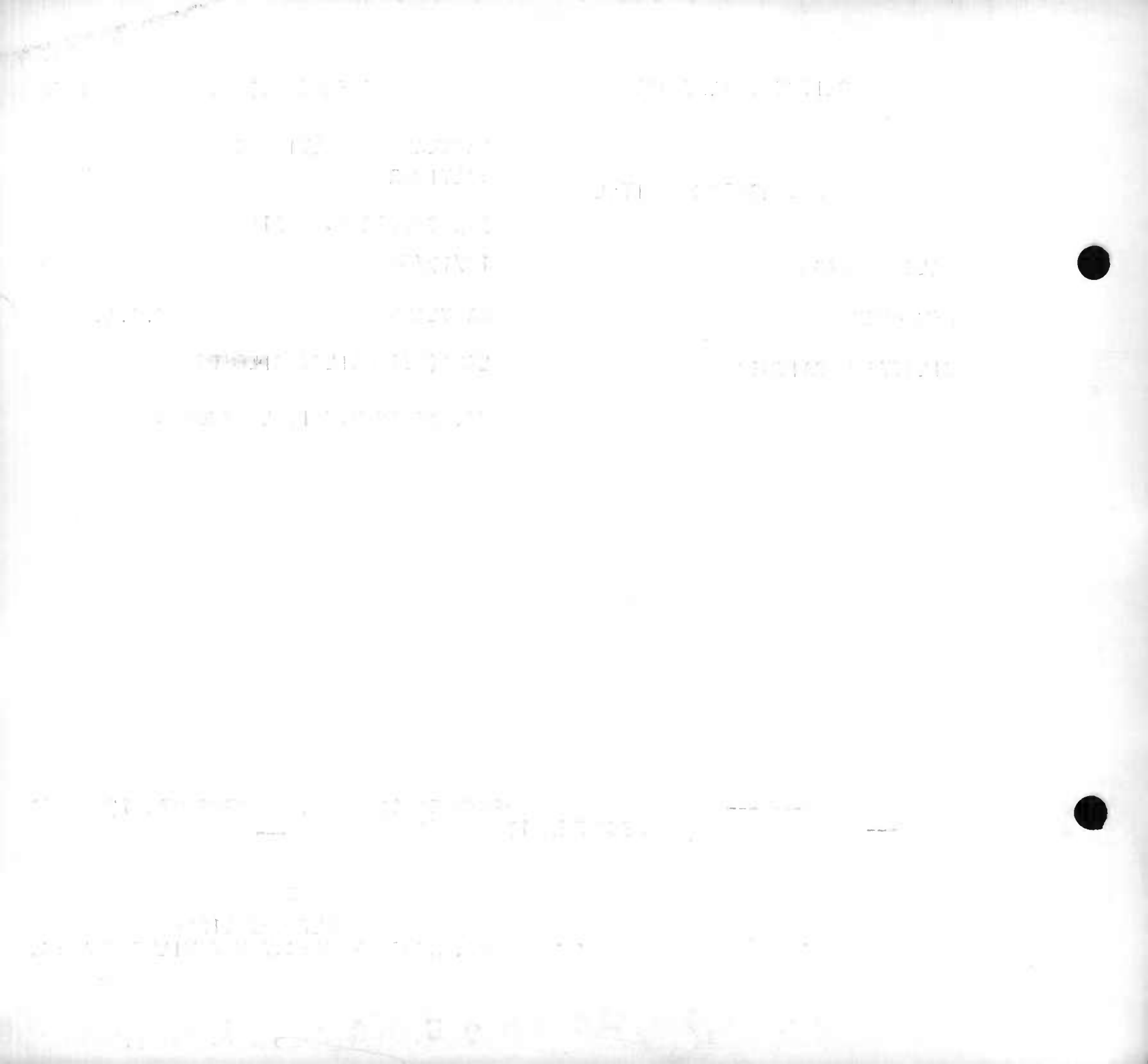
BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 69 12522	
5-562 69 12522		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <b>FLORENCE SOMMERS. Pearl</b>		2. DATE AND HOUR OF DEATH <b>17 DECEMBER 1969 4:25 A</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>SOUTH BALTIMORE GENERAL HOSPITAL</b>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>Baltimore</b> C. CITY OR TOWN <b>Woodlawn</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER <b>1910 Hillcrest Road</b>	
5. SEX <b>F</b>	6. RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10-4-01</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years lost birthday) <b>68</b>
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>JOHN GLENDENING</b>		14. MOTHER'S MAIDEN NAME <b>DORA CARSON</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS <b>Mr. Thomas M. Sommers, 1910 Hillcrest Rd</b>
18. I <b>251.9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH <b>SMALL BOWEL INFARCTION</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:  <b>MESENTERIC THROMBOSIS</b> (B) DUE TO, OR AS A CONSEQUENCE OF:  <b>DIABETES MELLITUS WITH ACIDOSIS</b> (C) <b>DIABETES MELLITUS WITH ACIDOSIS</b>  OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>Nephrosclerosis</b>	
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <b>(I)</b> (this hospital) attended the deceased from <b>DEC 16</b> 19 <b>69</b> to <b>Dec 17</b> 19 <b>69</b> , that <b>(I)</b> (we) last saw the deceased alive on <b>Dec 17</b> 19 <b>69</b> and that in <b>(my)</b> (our) opinion death occurred on the date and hour and from the causes stated above. <b>(I)</b> (We) (did) (did not) view the body after death.			
23A. SIGNATURE <b>William Eric Sohr M.D.</b>		23B. DATE SIGNED <b>17 Dec 1969</b>	
23C. PHYSICIAN'S NAME (Type) <b>William Eric Sohr, M. D.</b>		23D. ADDRESS <b>South Baltimore General Hospital</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>12/20/69</b>	24C. NAME OF CEMETERY or CREMATORY <b>Lorraine Park Cemetery</b>	24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 19 1969</b>		25B. NAME OF REGISTRAR <b>Witzke, Inc. 1630 edmondson Ave.</b>	
25C. FUNERAL DIRECTOR <b>Witzke, Inc. 1630 edmondson Ave.</b>		25D. ADDRESS <b>Witzke, Inc. 1630 edmondson Ave.</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

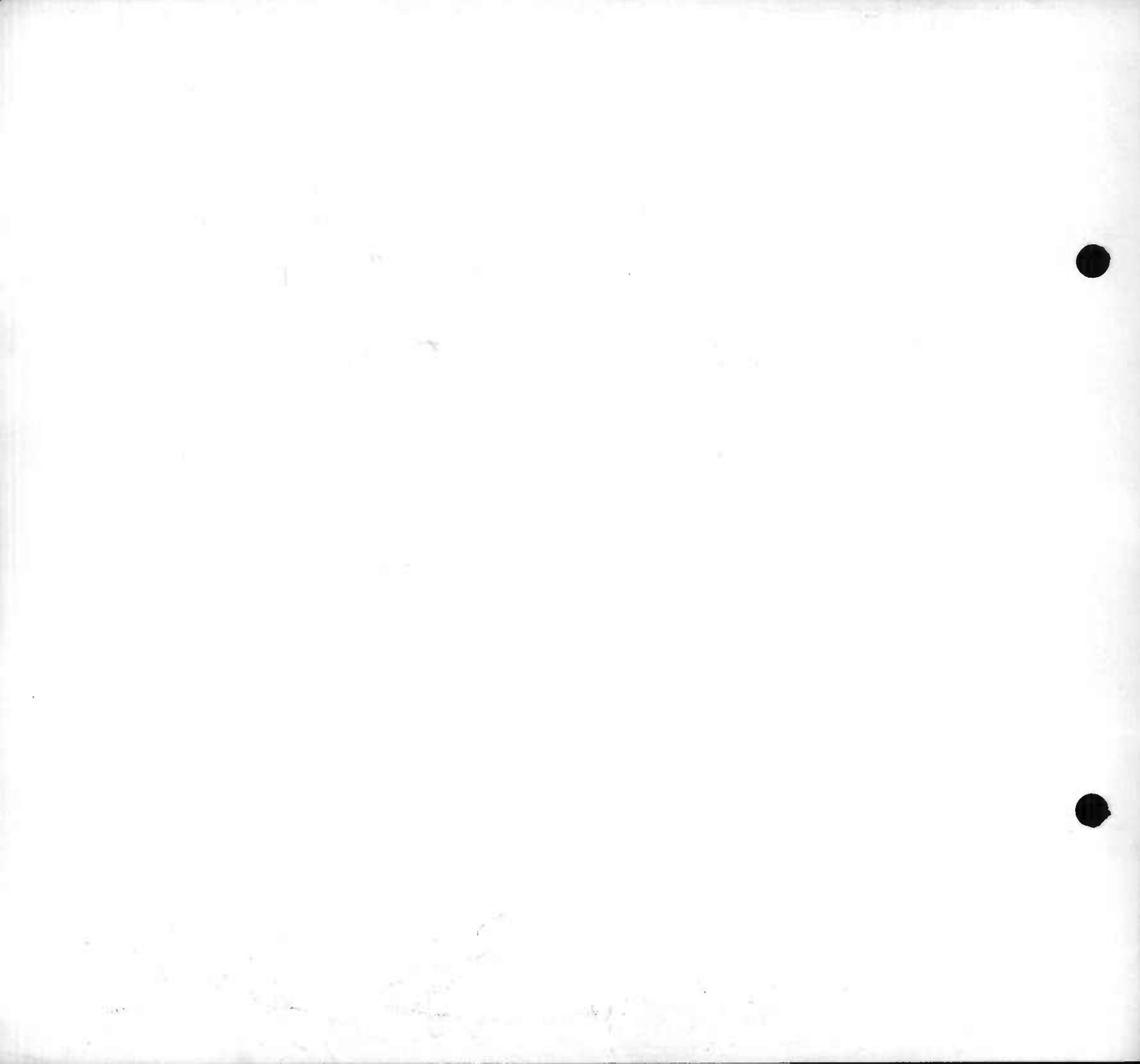
BALTIMORE CITY HEALTH DEPARTMENT		X		REG. NO. <u>69 12523</u>	
G-360 <u>69-23305</u> <u>69 12523</u>		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>GAITHER, BABY BOY GILLETTE Wm.</u>		2. DATE AND HOUR OF DEATH <u>DECEMBER 17, 1969</u> <u>2:25P</u> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION <u>40</u> <u>ST. AGNES HOSPITAL</u> (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>BALTIMORE</u> C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER <u>329 SUTTER RD 21228</u>			
5. SEX <u>MALE</u>	6. RACE <u>NEGRO</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/17/69</u>	9. AGE (In years last birthday)	10. Under 1 Yr. Months Days Hours Min. <u>2 09</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		13. FATHER'S NAME <u>GILLETTE W GAITHER</u>			
14. MOTHER'S MAIDEN NAME <u>LENA (NEE BAILEY) GAITHER</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) <u>—</u> If yes, give war or dates of service			
16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT ADDRESS <u>ST. AGNES HOSPITAL RECORDS</u>			
18. <u>777 X I</u> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Immaturity</u> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>NO</u>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) <u>(X) at this hospital</u> attended the deceased from <u>DECEMBER 17</u> 19 <u>69</u> to <u>DECEMBER 17</u> 19 <u>69</u> that <u>(1) (we)</u> lost saw the deceased alive on <u>DECEMBER 17</u> 19 <u>69</u> and that <u>(1) (we)</u> opinion death occurred on the date and hour and from the causes stated above. <u>(1) (we)</u> (did) (did not) view the body after death.					
23A. SIGNATURE <u>S. Aziz</u>		23B. DATE SIGNED <u>12/18/69</u>		23C. PHYSICIAN'S NAME (Type) <u>S. Aziz</u> M.d. DEGREE	
23D. ADDRESS <u>BALTO, MD 21229</u>		23E. ADDRESS <u>ST. AGNES HOSP: CATON &amp; WILKENS AVES.</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>12-22-69</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Balto. Nat'l. Cem</u>	
24D. LOCATION (City, town, or county) <u>Balto. Md.</u>		24E. STATE (State) <u>Md.</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>DEC 19 1969</u>		25B. NAME OF REGISTRAR <u>Robert E. Bailey</u>		25C. FUNERAL DIRECTOR <u>B. BAILEY</u> ADDRESS <u>1348 N. Calhoun St</u>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

J-525		69 12524		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO.		69 12524	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) ETOLKA JOHNSON				2. DATE AND HOUR OF DEATH DEC 4 1969 10 <sup>00</sup> P M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		A. STATE MARYLAND		B. COUNTY		1506	
FULL NAME OF HOSPITAL OR INSTITUTION 38 University Hospital Balto. md.		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
5. SEX F		6. RACE Neg		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6/25/62		9. AGE (in years last birthday) 9 yrs.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Franklin Johnson		14. MOTHER'S MAIDEN NAME Etolka Word.		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. None		17. INFORMANT Kenneth R Koskinen MD	
18. 746.4 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause [A] stating the UNDERLYING CONDITION last.		CAUSE OF DEATH cyanotic congenital heart disease (A) IMMEDIATE CAUSE IASD, IUSD, tricuspid atresia. DUE TO, OR AS A CONSEQUENCE OF: (B) _____ DUE TO, OR AS A CONSEQUENCE OF: (C) _____				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		(R) CVA - thrombosis II to polycythemia							
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from _____ 19 _____ to _____ 19 _____ that (I) (we) last saw the deceased alive on _____ 19 _____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE Kenneth Koskinen MD		23B. DATE SIGNED Dec 10, 1969		23C. PHYSICIAN'S NAME (Type) Kenneth Koskinen MD		23D. DATE SIGNED Dec 10, 1969			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 12-17-69		24C. NAME OF CEMETERY OR CREMATOR		24D. LOCATION (City, State, County) (State)			
25A. DATE REC'D BY HEALTH DEPT. DEC 19 1969		25B. NAME OF REGISTRAR John E. Kelly, Jr.		25C. FUNERAL DIRECTOR MORTUARY SERVICE - BCHD		25D. ADDRESS			



# FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <b>69 12525</b>	
H-460 69 12525		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <b>Baby Boy Hanratty - Haller</b>		2. DATE AND HOUR OF DEATH <b>10-Dec-69 11:35 A.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>South Baltimore Gen Hosp</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MD.</b> B. COUNTY <b>ANCO.</b> C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>4 Ballman Ct</b> <b>21225</b>	
5. SEX <b>M</b>	6. RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10-Dec-69</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <b>52.00</b> If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. <b>0 17</b>
11. BIRTHPLACE (State or foreign country) <b>MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Charles Haller</b>		14. MOTHER'S MAIDEN NAME <b>Linda Hanratty</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT <b>Mother</b> ADDRESS <b>Same</b>
18. <b>777 X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE <b>Premature - 482 gms</b> DUE TO, OR AS A CONSEQUENCE OF: (B) _____ DUE TO, OR AS A CONSEQUENCE OF: (C) _____  APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>17 mins.</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION <b>0</b>	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) <b>No</b>	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (nearly medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I certify that <del>(H)</del> (this hospital) attended the deceased from <b>10-Dec</b> 19 <b>69</b> to <b>10-Dec</b> 19 <b>69</b> , that <del>(H)</del> (we) last saw the deceased alive on <b>10-Dec</b> 19 <b>69</b> and that in (my) <del>(our)</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>(we)</del> (did) <del>(did not)</del> view the body after death.			
23A. SIGNATURE <b>Richard E. Fisher</b> DEGREE		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>	23B. DATE SIGNED <b>10-Dec-69</b>
23C. PHYSICIAN'S NAME (Type) <b>Richard E. Fisher</b> DEGREE		23D. ADDRESS <b>ANATOMY BOARD OF MARYLAND</b>	
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE <b>12-18-69</b>	24C. NAME OF CEMETERY or CREMATORIUM	24D. LOCATION (City, town, or county) (State) <b>JOHNS HOPKINS MEDICAL SCHOOL</b>
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 19 1969</b>		25B. NAME OF REGISTRAR <b>PHILIP J. ...</b>	
<b>MORTUARY SERVICE - BCHD</b>			





# FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <b>69 12526</b>	
W-425 69 12526		BIRTH NO. <b>69-22393</b>	
1. NAME OF DECEASED (Type or Print) <b>Barry Boy Wilson</b>		2. DATE AND HOUR OF DEATH <b>12-7-69 5:12 P.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>43 SOUTH BALTO. GEN. HOSP.</b>		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>2532</b>	
5. SEX <b>M</b> 6. RACE <b>C</b> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Balto.</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		E. STREET AND NUMBER <b>2218 Round Rd.</b>	
10B. KIND OF BUSINESS OR INDUSTRY		9. AGE (In years last birthday) <b>12-7-69</b>	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Lincol Moore Wilson</b>		14. MOTHER'S MAIDEN NAME <b>EYVONNE Wilson</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Mother</b>		ADDRESS	
18. <b>776.1 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>thymic Neoplasia</b>		CAUSE OF DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>thymic Neoplasia</b> (B) <b>Neuroblastoma</b> (C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) <b>Yes</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>12-7-1969</b> to <b>12-7-1969</b> , that (I) (we) lost saw the deceased alive on <b>12-7-1969</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <b>Alyde A. Melocorn MD</b>		23B. DATE SIGNED <b>11-7-69</b>	
23C. PHYSICIAN'S NAME (Type) <b>ALYDE A. MELOCORN</b>		23D. ADDRESS <b>ANATOMY BOARD OF MARYLAND</b>	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <b>12-18-69</b>	
24C. NAME OF CEMETERY OR CREMATORY <b>JOHNS HOPKINS MEDICAL SCHOOL</b>		24D. LOCATION (City, town, or county) (State)	
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 19 1969</b>		25B. NAME OF REGISTRAR <b>Robert E. Fisher, Md.</b>	
25C. FUNERAL DIRECTOR		ADDRESS <b>MORTUARY SERVICE - BCHD</b>	



FUNERAL DIRECTOR: IMPORTANT

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<p><b>G-600</b> 69 12527 <b>BALTIMORE CITY HEALTH DEPARTMENT</b></p> <p><b>CERTIFICATE OF DEATH</b></p>		<p>REG. NO. 69 12527</p>	
<p>BIRTH NO. 69-21942</p>		<p>1. NAME OF DECEASED (Type or Print) <i>Baby Boy Gray</i></p>	
<p>2. DATE AND HOUR OF DEATH <i>11/25/69 11:15 AM</i></p>		<p>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</p>	
<p>4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>Baltimore</i> B. COUNTY <i>1605</i></p>		<p>5. FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>University Hospital</i></p>	
<p>6. CITY OR TOWN <i>Baltimore</i></p>		<p>7. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></p>	
<p>8. STREET AND NUMBER <i>614 N Pulaski St.</i></p>		<p>9. SEX <i>F</i> 10. RACE <i>N</i></p>	
<p>11. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p>		<p>12. DATE OF BIRTH <i>11/25/69</i> 13. AGE (in years last birthday) <i>28</i></p>	
<p>14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>NB</i></p>		<p>15. KIND OF BUSINESS OR INDUSTRY</p>	
<p>16. BIRTHPLACE (State or foreign country) <i>Baltimore, Md.</i></p>		<p>17. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i></p>	
<p>18. FATHER'S NAME <i>?</i></p>		<p>19. MOTHER'S MAIDEN NAME <i>Phyllis Gray</i></p>	
<p>20. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)</p>		<p>21. SOCIAL SECURITY NO.</p>	
<p>22. INFORMANT ADDRESS</p>		<p>23. CAUSE OF DEATH</p>	
<p>18. <i>777X I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p>		<p>(A) IMMEDIATE CAUSE <i>Immaturity</i> DUE TO, OR AS A CONSEQUENCE OF: (B) _____ DUE TO, OR AS A CONSEQUENCE OF: (C) _____</p>	
<p>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>2 hours</i></p>		<p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</p>	
<p>19A. DATE OF OPERATION <i>0</i></p>		<p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</p>	
<p>20A. AUTOPSY? (Yes or No) <i>Yes</i></p>		<p>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</p>	
<p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)</p>		<p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>	
<p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p>		<p>21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)</p>	
<p>21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>		<p>21F. HOW DID INJURY OCCUR?</p>	
<p>22. I certify that (I) (this hospital) attended the deceased from <i>11-25 1969</i> to <i>11-25 1969</i> that (I) (we) last saw the deceased alive on <i>11-25 1969</i> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</p>			
<p>23A. SIGNATURE <i>J. de Castro - alonso</i></p>		<p>23B. DATE SIGNED <i>11/25/69</i></p>	
<p>23C. PHYSICIAN'S NAME (Type) <i>MA. JOSEFINA DE CASTRO - ALONSO</i></p>		<p>23D. ADDRESS <i>ANATOMY BOARD OF MARYLAND UNIVERSITY MEDICAL SCHOOL</i></p>	
<p>24A. BURIAL CREMATION, REMOVAL (Specify) <i>12-17-69</i></p>		<p>24B. DATE</p>	
<p>24C. NAME OF CEMETERY OR CREMATORY</p>		<p>24D. LOCATION (City, town, county) (State)</p>	
<p>25A. DATE REC'D BY HEALTH DEPT. <i>DEC 19 1969</i></p>		<p>25B. NAME OF REGISTRAR <i>Robert J. Kelly</i></p>	
<p>25C. FUNERAL DIRECTOR ADDRESS</p>		<p>25D. MORTUARY SERVICE - BCHD</p>	

Hospital said address  
is 616 N Pulaski St.

# FUNERAL DIRECTOR: IMPORTANT

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<div style="display: flex; justify-content: space-between;"> <span>H-622</span> <span>69 12528</span> <span>BALTIMORE CITY HEALTH DEPARTMENT</span> </div> <h2 style="text-align: center;">CERTIFICATE OF DEATH</h2>		REG. NO. <span style="font-size: 1.2em;">69 12528</span>	
BIRTH NO. <span style="font-size: 1.2em;">HRYCEJ THEODORES</span>		2. DATE AND HOUR OF DEATH <span style="font-size: 1.2em;">12-16-69 4.45 PM</span>	
1. NAME OF DECEASED (Type or Print)		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <span style="font-size: 1.2em;">BALTO. MD.</span> B. COUNTY	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION <span style="font-size: 1.2em;">THE UNION MEMORIAL HOSPITAL</span>		C. CITY OR TOWN <span style="font-size: 1.2em;">BALTIMORE</span> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <span style="font-size: 1.2em;">M.</span>		6. RACE <span style="font-size: 1.2em;">White</span>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <span style="font-size: 1.2em;">11-09-15</span>	
9. AGE (in years last birthday) <span style="font-size: 1.2em;">54</span>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">MECHANIC</span>	
11. BIRTHPLACE (State or foreign country) <span style="font-size: 1.2em;">ILLINOIS</span>		12. CITIZEN OF WHAT COUNTRY? <span style="font-size: 1.2em;">AMERICAN</span>	
13. FATHER'S NAME <span style="font-size: 1.2em;">JOHN HRYCEJ</span>		14. MOTHER'S MAIDEN NAME <span style="font-size: 1.2em;">ANNA SCHULTZ</span>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes WW 11 <span style="font-size: 1.2em;">XXXXXXXXXXXX</span>		16. SOCIAL SECURITY NO. <span style="font-size: 1.2em;">351-10-1274</span>	
17. INFORMANT <span style="font-size: 1.2em;">Mrs Ada L Hrycej</span>		ADDRESS <span style="font-size: 1.2em;">Same</span>	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <span style="font-size: 1.2em;">4 hours</span> <span style="font-size: 1.2em;">2 years</span> <span style="font-size: 1.2em;">2 years</span>	
19A. DATE OF OPERATION <span style="font-size: 1.2em;">2 years ago</span>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <span style="font-size: 1.2em;">Ca of Rectum</span>	
20A. AUTOPSY? (Yes or No) <span style="font-size: 1.2em;">no</span>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <span style="font-size: 1.2em;">no</span>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <span style="font-size: 1.2em;">no</span>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <span style="font-size: 1.2em;">no</span>	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <span style="font-size: 1.2em;">no</span>		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) <span style="font-size: 1.2em;">no</span>	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <span style="font-size: 1.2em;">no</span>	
22. I certify that (I) (this hospital) attended the deceased from <span style="font-size: 1.2em;">12-15</span> 19 <span style="font-size: 1.2em;">69</span> to <span style="font-size: 1.2em;">12-16</span> 19 <span style="font-size: 1.2em;">69</span> that (I) (we) last saw the deceased alive on <span style="font-size: 1.2em;">2 PM 12-16</span> 19 <span style="font-size: 1.2em;">69</span> and that in <span style="font-size: 1.2em;">my</span> (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <span style="font-size: 1.2em;">A. Moazzzadeh M.D.</span>		23B. DATE SIGNED <span style="font-size: 1.2em;">12-16-69</span>	
23C. PHYSICIAN'S NAME (Type) <span style="font-size: 1.2em;">ABDOLREZA MOAZZENSADAH M.D.</span>		23D. ADDRESS <span style="font-size: 1.2em;">UNION MEMORIAL HOSPITAL</span>	
24A. BURIAL CREMATION, REMOVAL (Specify) <span style="font-size: 1.2em;">Burial</span>		24B. DATE <span style="font-size: 1.2em;">12/19/69</span>	
24C. NAME OF CEMETERY OR CREMATORY <span style="font-size: 1.2em;">Holly Hill</span>		24D. LOCATION (City, town, or county) (State) <span style="font-size: 1.2em;">Baltimore, Maryland</span>	
25A. DATE REC'D BY HEALTH DEPT. <span style="font-size: 1.2em;">DEC 19 1969</span>		25B. NAME OF REGISTRAR <span style="font-size: 1.2em;">Robert E. Jaber, M.D.</span>	
25C. FUNERAL DIRECTOR <span style="font-size: 1.2em;">Leonard J. Rutk Inc</span>		ADDRESS <span style="font-size: 1.2em;">Baltimore, Maryland</span>	

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

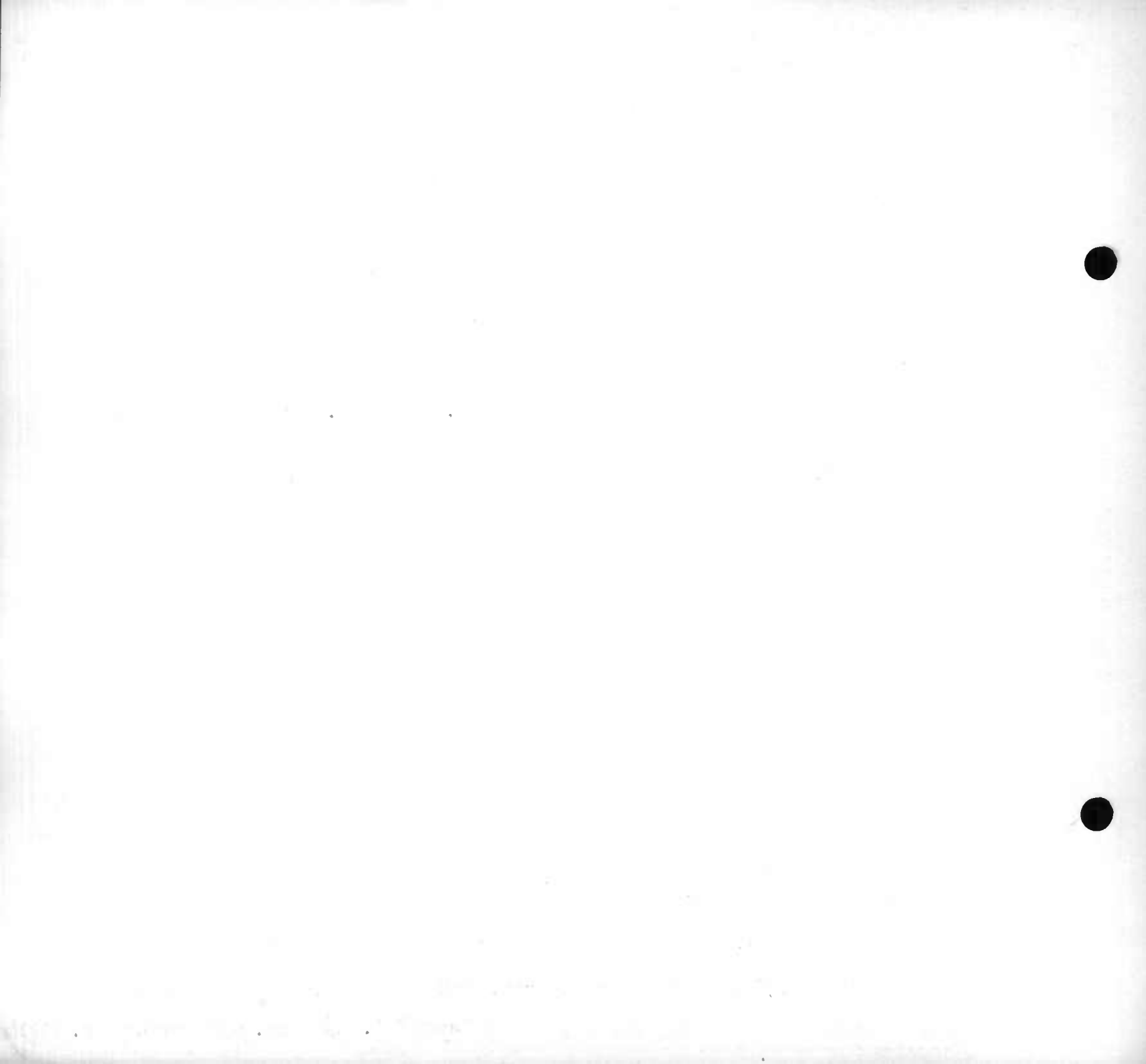
<div style="display: flex; justify-content: space-between;"> <span>7-460</span> <span>69 12529</span> <span>BALTIMORE CITY HEALTH DEPARTMENT</span> </div> <h2 style="text-align: center;">CERTIFICATE OF DEATH</h2> <div style="display: flex; justify-content: space-between;"> <span>REG. NO.</span> <span>69 12529</span> </div>			
BIRTH NO. <span style="float: right;">1</span> 1. NAME OF DECEASED (Type or Print) <span style="margin-left: 100px;">LEONIA</span> <span style="margin-left: 50px;">M.</span> <span style="margin-left: 50px;">TAYLOR</span>		2. DATE AND HOUR OF DEATH Dec. 16, 1969 <span style="float: right;">8<sup>10</sup> P</span> <span style="float: right;">M.</span>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <div style="display: flex; align-items: center;"> <span style="font-size: 2em; margin-right: 10px;">90</span> <span>GOULD CONVALESARIUM</span> </div>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <span style="margin-left: 100px;">Md.</span> B. COUNTY <span style="float: right;">2733</span> C. CITY OR TOWN <span style="margin-left: 100px;">Baltimore</span> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <span style="margin-left: 100px;">3209 Batavia Avenue</span>	
5. SEX female	6. RACE caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 13, 1900.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <span style="margin-left: 100px;">69</span> If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Conrad Kness		14. MOTHER'S MAIDEN NAME Appleonia Wagner	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 215-01-0969	
17. INFORMANT Mr. John C. Taylor		ADDRESS 5614 Whitby Rd. 21206	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Right Lower Lobe Pneumonia</i> (B) DUE TO, OR AS A CONSEQUENCE OF: (C)	
19. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <span style="margin-left: 100px;">9/16/1969</span> to <span style="margin-left: 100px;">12/16/1969</span> that (I) ( <del>we</del> ) last saw the deceased alive on <span style="margin-left: 100px;">12/16/1969</span> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>we</del> ) ( <del>did not</del> ) view the body after death.			
23A. SIGNATURE <i>Albert B. Bradley</i>		23B. DATE SIGNED 12/17/69	
23C. PHYSICIAN'S NAME (Type) Dr. Albert B. Bradley		23D. ADDRESS 4900 Belair Road, Balto, Md.	
24A. BURIAL CREMATION REMOVAL (Specify) Burial		24B. DATE 12/20/69.	
24C. NAME OF CEMETERY or CREMATORY Holy Redeemer Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. DEC 19 1969		25B. NAME OF REGISTRAR Robert E. Taylor	
25C. FUNERAL DIRECTOR Leonard J. Ruck, Inc.		ADDRESS Balto, Md. -14	





This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <b>69 12530</b>	
<b>CERTIFICATE OF DEATH</b>			
BIRTH NO. <b>S-620</b>		69 12530	
1. NAME OF DECEASED (Type or Print) <b>Frances ANNA SPRIGGS</b>		2. DATE AND HOUR OF DEATH <b>12-15-69 11:45 P.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <b>7 Mercy</b>		4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <b>MD.</b> B. COUNTY <b>2745</b>	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>7 Mercy</b>		C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER <b>6601 Walther Ave. 21206</b>	
5. SEX <b>F</b>	6. RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8-26-02</b>
		9. AGE (in years last birthday) <b>67</b>	10. CITIZEN OF WHAT COUNTRY? <b>USA</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Home maker</b>		11. BIRTHPLACE (State or foreign country) <b>Philadelphia, PA.</b>	
13. FATHER'S NAME <b>Vincent Dudonis</b>		14. MOTHER'S MAIDEN NAME <b>Laura Rebner</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
		17. INFORMANT <b>Mr. Raymond R. Spriggs</b> ADDRESS <b>Same</b>	
18. <b>I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>Myocardial Infarction</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			
19A. DATE OF OPERATION <b>12-15-69</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>YES</b>	
20A. AUTOPSY? (Yes or No) <b>YES</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>YES</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>11-30-1969</b> to <b>12-15-1969</b> that (I) (we) last saw the deceased alive on <b>12-15-1969</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <b>Bayani L. Manalo</b>		23B. DATE SIGNED <b>12-16-69</b>	
23C. PHYSICIAN'S NAME (Type) <b>BAYANI L. MANALO M.D.</b>		23D. ADDRESS <b>6 Mercy Hospital</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12/19/69</b>	
24C. NAME OF CEMETERY OR CREMATORY <b>Lake View Memorial Park</b>		24D. LOCATION (City, town, or county) (State) <b>Carroll County Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 19 1969</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>	
25C. FUNERAL DIRECTOR <b>Leonard J. Ruck Inc.</b>		ADDRESS <b>5305 Harford Rd. 21211</b>	



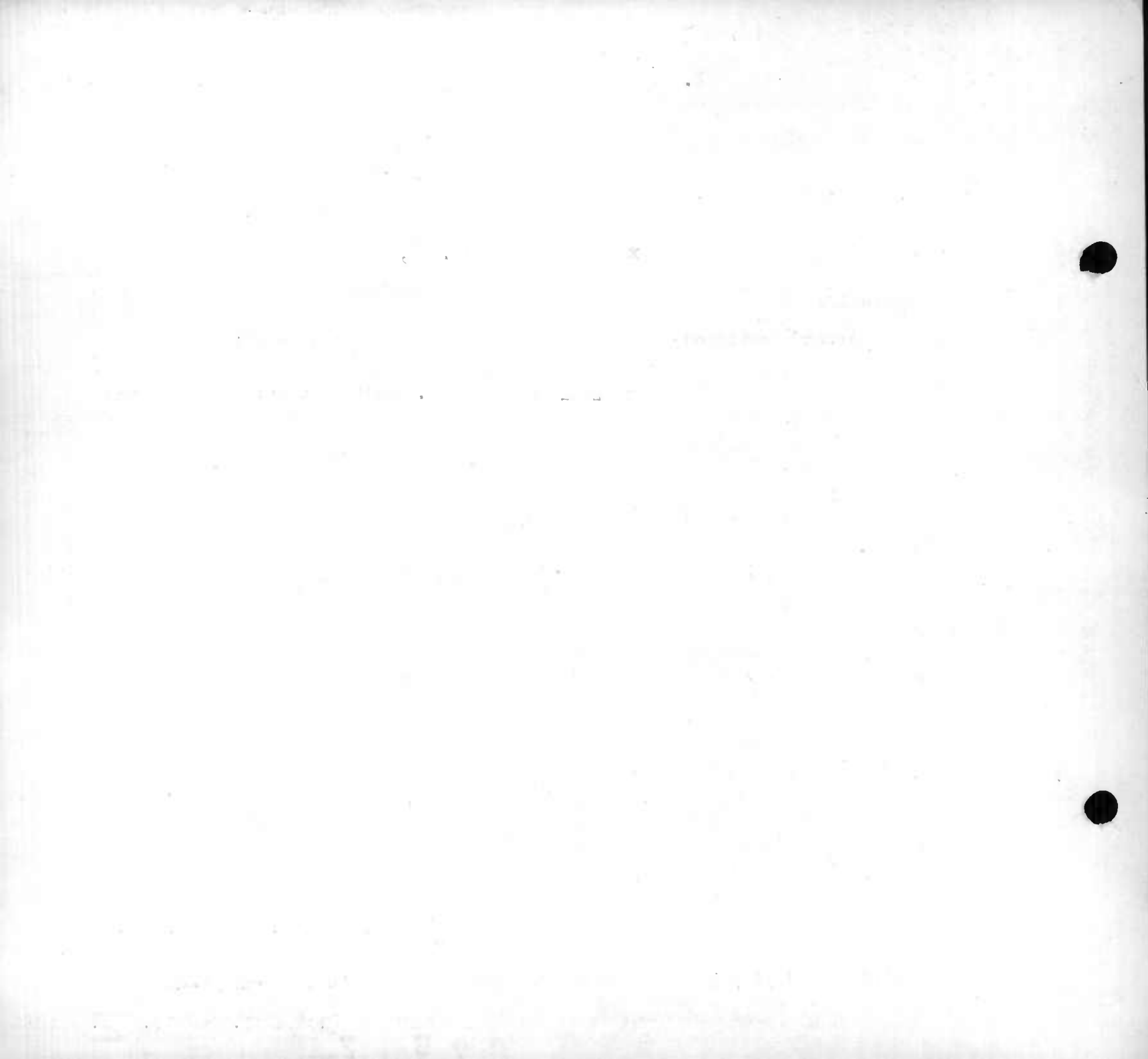
BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		MEDICAL EXAMINER'S CERTIFICATE OF DEATH		REG. NO. 69 12531	
1. NAME OF DECEASED (Type or Print) Robert Batterden				2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour 12 15 69 3:40 p. m.			
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 40 St. Agnes Hospital				3. DATE PRONOUNCED DEAD Month Day Year Hour 12 15 69 3:40 p. m.			
6. SEX male				7. RACE white		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH 12/15/22				10. AGE (In years lost birthday) 47		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 903	
11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? USA		C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Guard				14B. KIND OF BUSINESS OR INDUSTRY Racing Commission		13. FATHER'S NAME James E. Batterden	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give wpc or dates of service) Yes W W II				17. SOCIAL SECURITY NO 217-18-5820		15. MOTHER'S MAIDEN NAME Elizabeth M. Noonan	
18. INFORMANT Mr. John T. Batterden				ADDRESS 3632 Yolanda Rd.			
19. 441.0 I CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE Dissecting aneurysm of aortic arch with hemo-pericardium DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.				(B) DUE TO, OR AS A CONSEQUENCE OF:			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				(C)			
20A. DATE OF OPERATION				20B. CONDITION FOR WHICH OPERATION WAS PERFORMED			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?				22D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)			
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				22F. HOW DID INJURY OCCUR?			
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <i>Werner U. Spitz</i> M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED EXAMINER'S NAME (Type) Werner U. Spitz, M.D. Deputy Chief Medical Examiner 12/16/69 ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>							
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/19/69		24C. NAME of CEMETERY or CREMATORY Baltimore National Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore Maryland	
25A. DATE REC'D BY HEALTH DEPT. DEC 19 1969		25B. NAME OF REGISTRAR Robert E. Gabel		25C. FUNERAL DIRECTOR Leonard J. Ruck Inc.		ADDRESS 5305 Harford Rd. 21214	

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# FUNERAL DIRECTOR: IMPORTANT

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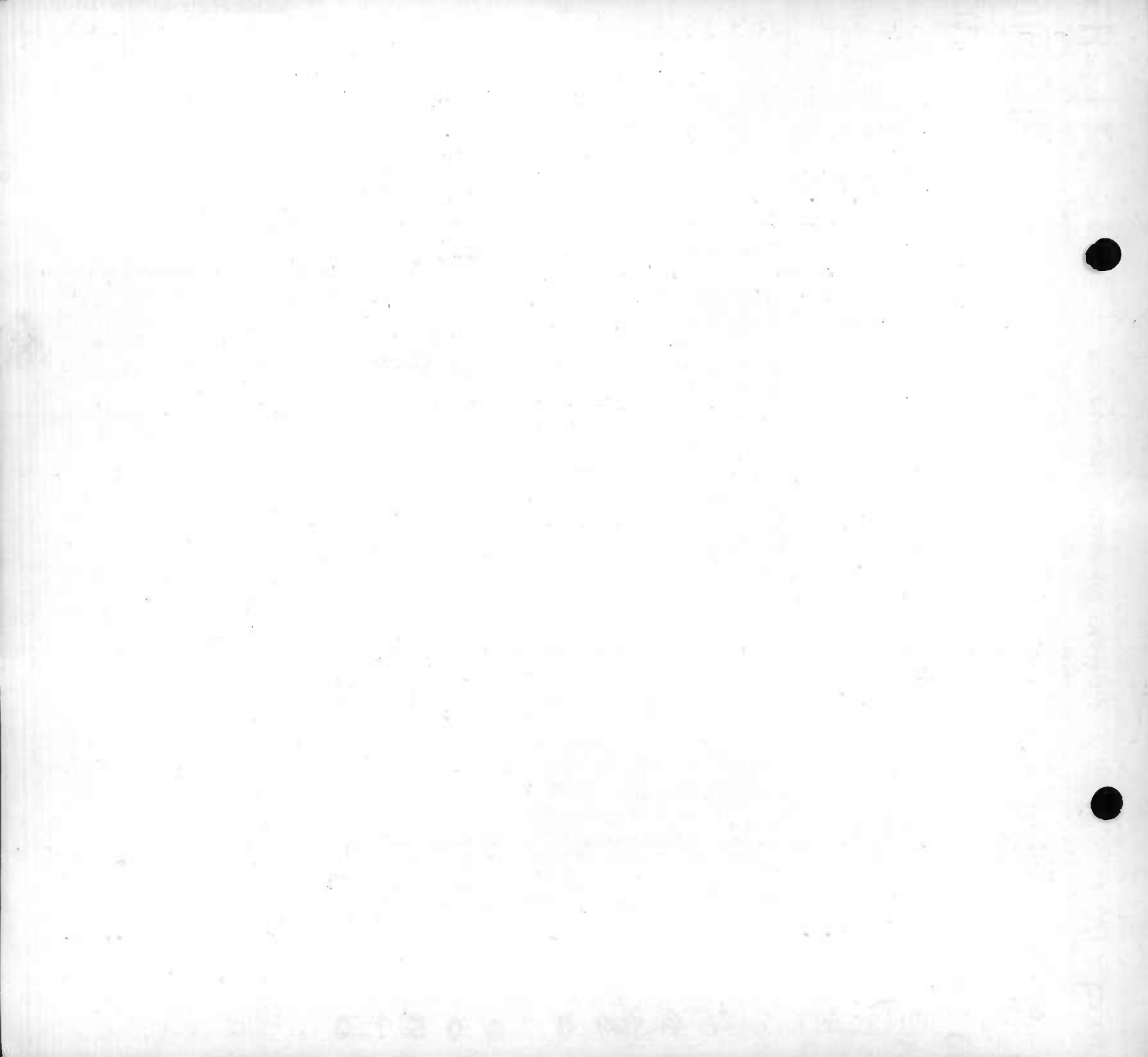
BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <span style="float: right;">69 12532</span>	
A-536 69 12532		CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>JENNIE I. ANDERSON</b>	
2. DATE AND HOUR OF DEATH <b>December 16, 1969</b> <span style="float: right;">8:30 A.M.</span>		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD	
FULL NAME OF HOSPITAL OR INSTITUTION <b>3018 Overland Ave.</b>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)	
4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>2702</b>		C. CITY OR TOWN <b>Baltimore</b>	
D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		E. STREET AND NUMBER <b>3018 Overland Ave.</b>	
5. SEX <b>Female</b>	6. RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 24, 1880</b>
9. AGE (In years last birthday) <b>89</b>		10. Under 1 Yr. Months: Days: Hours: Min.	11. Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>England</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Richard Hewittson</b>		14. MOTHER'S MAIDEN NAME <b>Jane Sewell</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>166-05-1101</b>	17. INFORMANT <b>Mrs. Evelyn Hackett</b>
ADDRESS <b>Same</b>			
18. <b>250.9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <b>Antecedent Causes</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE, DUE TO, OR AS A CONSEQUENCE OF: <b>Acute Myocardial Infarction</b> (B) DUE TO, OR AS A CONSEQUENCE OF: <b>A.S.U.D.</b> (C) <b>Diabetes Mellitus</b>	
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>12/15/69</b> <b>2 yrs.</b> <b>25 yrs.</b>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION <b>0</b>	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) <b>No</b>	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>1948</b> 19 to <b>12/16/69</b> 19, that (I) (we) last saw the deceased alive on <b>12/15/69</b> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <b>Robert E. Hackett M.D.</b>		23B. DATE SIGNED <b>12/16/69</b>	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS <b>4331 Harford Rd., Balto. Md.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>12/19/69</b>	24C. NAME OF CEMETERY or CREMATORY <b>Arlington Cemetery</b>	24D. LOCATION (City, town, or county) (State) <b>Yeadon Pennsylvania</b>
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 19 1969</b>		25B. NAME OF REGISTRAR <b>Robert E. Hackett, M.D.</b>	25C. FUNERAL DIRECTOR <b>Leonard J Ruck Inc. Balto. Md. 21214</b>
ADDRESS			



# FUNERAL DIRECTOR: IMPORTANT

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BIRTH NO. <span style="float: right;">K-256</span>				69 12533		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <span style="float: right;">69 12533</span>	
1. NAME OF DECEASED (Type or Print) <b>KAZMIERSKI, EDWARD W.</b>				2. DATE AND HOUR OF DEATH <b>12/17/69 4:15 P.M.</b>					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>Baltimore City Hospital 4940 Eastern Avenue Baltimore, Md. 21224</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>2401</b>					
5. SEX <b>Male</b>				6. RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>10/21/05</b>	
9. AGE (In years lost birthday) <b>64</b>				10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Stevenson</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Ignatius Kazmierski</b>				14. MOTHER'S MAIDEN NAME <b>Christine Nickles</b>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>216-03-7366</b>		17. INFORMANT <b>Records: BCH 4940 Eastern Avenue 21224</b>			
18. <b>436.9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				CAUSE OF DEATH (A) IMMEDIATE CAUSE <b>CUA</b> DUE TO, OR AS A CONSEQUENCE OF:  (B) _____ DUE TO, OR AS A CONSEQUENCE OF:  (C) _____				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION <b>0</b>				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (1) (this hospital) attended the deceased from <b>12/17/69</b> 19 to <b>12/17/69</b> 19, that (1) (we) lost saw the deceased alive on _____ 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <b>J.R. Wands</b>				23B. DATE SIGNED <b>12/17/69</b>		23C. PHYSICIAN'S NAME (Type) <b>J.R. Wands</b>			
23D. ADDRESS <b>Baltimore City Hospital 4940 Eastern Avenue Balto., Md.</b>				23E. FUNERAL DIRECTOR <b>Charles L. Stevens Funeral Home, Inc.</b>					
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>				24B. DATE <b>12/20/69</b>		24C. NAME OF CEMETERY or CREMATORY <b>Holy Cross Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 19 1969</b>				25B. NAME OF REGISTRAR <b>James E. Taylor</b>		25C. ADDRESS <b>9515 00 East Fort Avenue</b>			





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.	69 12534
S-400 69 12534		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <i>Catherine M. Saul</i>		2. DATE AND HOUR OF DEATH <i>12-15-69 9:00 A. M.</i>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>1440 Hubert St. 00 Baltimore, Md.</i>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>2401</i> C. CITY OR TOWN <i>Baltimore</i> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <i>1440 Hubert St.</i>			
5. SEX <i>F</i>	6. RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>2/5/01</i>	9. AGE (In years last birthday) <i>68</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Officer Worker</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Hosiery Co</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>
13. FATHER'S NAME <i>Joseph Meininger</i>		14. MOTHER'S MAIDEN NAME <i>Marie Weber</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>219-10-8192</i>		17. INFORMANT ADDRESS <i>Mr. Emil M. Saul 1440 Hubert St.</i>	
18. CAUSE OF DEATH					
<div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <p>18. <i>348.0 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)</p> <p>ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last,</p> </div> <div style="width: 50%;"> <p>(A) IMMEDIATE CAUSE <i>Cardio-respiratory arrest</i> DUE TO, OR AS A CONSEQUENCE OF:</p> <p>(B) <i>Respiratory paralysis</i> DUE TO, OR AS A CONSEQUENCE OF:</p> <p>(C) <i>Amyotrophic lateral sclerosis</i></p> </div> </div>					
<div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <p>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <i>Severe dehydration &amp; malnutrition.</i></p> </div> <div style="width: 50%;"> <p>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</p> </div> </div>					
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>September 1969</i> to <i>December 15 1969</i> , that (I) (we) last saw the deceased alive on <i>December 15 1969</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>C. Palad</i> DEGREE				23B. DATE SIGNED <i>December 17, 1969</i>	
23C. PHYSICIAN'S NAME (Type) <i>Consolador C. Palad, Jr., M.D.</i> DEGREE				23D. ADDRESS <i>1228 South Charles Street, Baltimore 30 Md.</i>	
24A. BURIAL CREMATION REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>12/19/69</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Holy Cross Cemetery</i>	
				24D. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>DEC 19 1969</i>		25B. NAME OF REGISTRAR <i>Robert E. Taylor</i>		25C. FUNERAL DIRECTOR <i>Charles L. Stevens Funeral Home, Inc.</i> ADDRESS <i>1801 East Fort Avenue</i>	



BIRTH NO.		69 12535 BALTIMORE CITY HEALTH DEPARTMENT		69 12535	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH				REG. NO.	
1. NAME OF DECEASED (Type or Print) Mary L. Hubbard		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> 12 14 69		Hour M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Lutheran Hospital (DOA)		3. DATE PRONOUNCED DEAD Month Day Year 12 14 69		Hour 12:45 P.M.	
6. SEX Female		7. RACE Negro		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH 9-13-37		10. AGE (In years lost birthday) 32		11. BIRTHPLACE (State or foreign country) S. Carolina	
12. CITIZEN OF USA		13. FATHER'S NAME James Johnson		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk Typist	
15. MOTHER'S MAIDEN NAME Lela May Johnson		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO. 250-56-9584	
18. INFORMANT Mr. Joseph Hubbard		19. ADDRESS 119 S. Loudon Avenue		20. DATE OF OPERATION	
21. CAUSE OF DEATH Cardiac arrhythmia with ventricular extrasystoles		22. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		23. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
24. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		25. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		26. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).	
27. DATE OF OPERATION		28. CONDITION FOR WHICH OPERATION WAS PERFORMED		29. AUTOPSY? (Yes or No) yes	
30. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		31. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)		32. HOW DID INJURY OCCUR?	
33. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		34. ACTUAL SIGNATURE Russell S. Fisher, M.D.		35. DATE SIGNED 12-15-69	
36. BURIAL CREMATION, REMOVAL (Specify) Burial		37. DATE 12-18-69		38. NAME OF CEMETERY or CREMATORY Baltimore National Cem.	
39. DATE REC'D BY HEALTH DEPT. DEC 19 1969		40. NAME OF REGISTRAR Robert E. Fisher, M.D.		41. FUNERAL DIRECTOR Nutter Funeral Home	
42. ADDRESS 3035 W. North Ave.		43. DATE 12-15-69		44. TIME 12:45 P.M.	

4/2/84

WATER PROLOGUE

WATER PROLOGUE

WATER PROLOGUE

WATER PROLOGUE

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.	
D-520		69 12536		69 12536	
<b>CERTIFICATE OF DEATH</b>					
BIRTH NO.		1			
1. NAME OF DECEASED (Type or Print)			2. DATE AND HOUR OF DEATH		
DENNIS, Charles Ray			12-15-69 12:30 A M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			A. STATE B. COUNTY		
Veterans Administration Hospital 3900 Loch Raven Boulevard Baltimore, Maryland 21218			Maryland 1510		
C. CITY OR TOWN			D. INSIDE CITY LIMITS?		
Baltimore			YES <input type="checkbox"/> NO <input type="checkbox"/>		
E. STREET AND NUMBER			3937 Boarman Avenue		
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. Under 1 Yr. Months: Days: 11. Under 24 Hrs. Hours: Min.
Male	Negro	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	1-15-19	50	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Factory Worker		Johnson Chemical Co.		Gloucester, Va	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
Thomas Dennis			Marie King		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
Yes 1-6-44 to 9-26-44		220-01-35-86		Mrs. Pearl Dennis 3937 Boarman Avenue	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			CAUSE OF DEATH		
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)			BRONCHOGENIC CARCINOMA WITH WIDESPREAD METASTASES.		
ANTECEDENT CAUSES			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) DUE TO, OR AS A CONSEQUENCE OF:		
			(C) DUE TO, OR AS A CONSEQUENCE OF:		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			OLD SUBDURAL HEMATOMA, TREATED.		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
				YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that XX (this hospital) attended the deceased from October 14, 1969 to December 15, 1969, that X (we) last saw the deceased alive on December 15, 1969 and that in XX (our) opinion death occurred on the date and hour and from the causes stated above. XX (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
DAVID N. MARINE, M.D.				12/16/69	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
		3900 Loch Raven Boulevard Baltimore, Maryland 21218			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
Burial		12-19-69		Baltimore National Cemetery Baltimore Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
DEC 19 1969		Robert E. Taylor, M.D.		Nutter Funeral Home 3035 W. North Ave.	



M-340		69 12537		BALTIMORE CITY HEALTH DEPARTMENT		MEDICAL EXAMINER'S CERTIFICATE OF DEATH		69 12537	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE OF DEATH		3. DATE PRONOUNCED DEAD		4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD	
		Mildred Madelo		Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> M.		Month Day Year Hour 12 7 1969 9:25 A.M.		FULL NAME OF HOSPITAL OR INSTITUTION 1829 N. Charles St.	
6. SEX Female		7. RACE White		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Balto.		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
9. DATE OF BIRTH		10. AGE (In years lost birthday) 71		If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.		E. STREET AND NUMBER 1829 N. Charles St.		11. BIRTHPLACE (State or foreign country) NORTH CAROLINA	
								12. CITIZEN OF WHAT COUNTRY? U.S.A.	
								13. FATHER'S NAME WOODDELL	
								14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE	
								15. MOTHER'S MAIDEN NAME UNKNOWN	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) NO		17. SOCIAL SECURITY NO.		18. INFORMANT RICHARD A. ADAMS		ADDRESS 1119 GEORGIA AVE WHEATON, MD.			
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH 412.4 I (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH Arteriosclerotic cardiovascular disease		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:							
		(B) DUE TO, OR AS A CONSEQUENCE OF:							
		(C) DUE TO, OR AS A CONSEQUENCE OF:							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).									
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) no					
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
22D. TIME (Month) (Day) (Year) (Hour) (Approx.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?					
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Russell S. Fisher, M.D.		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 12-8-69					
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 12-15-69		24C. NAME OF CEMETERY or CREMATORY GLEN HAVEN		24D. LOCATION (City, town, or county) (State) GLEN BURNIE, MD.			
25A. DATE REC'D BY HEALTH DEPT. DEC 19 1969		25B. NAME OF REGISTRAR Russell S. Fisher, M.D.		25C. FUNERAL DIRECTOR H. J. TUCKER & SONS		ADDRESS BALTO. MD.			

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WALL RAY KONG

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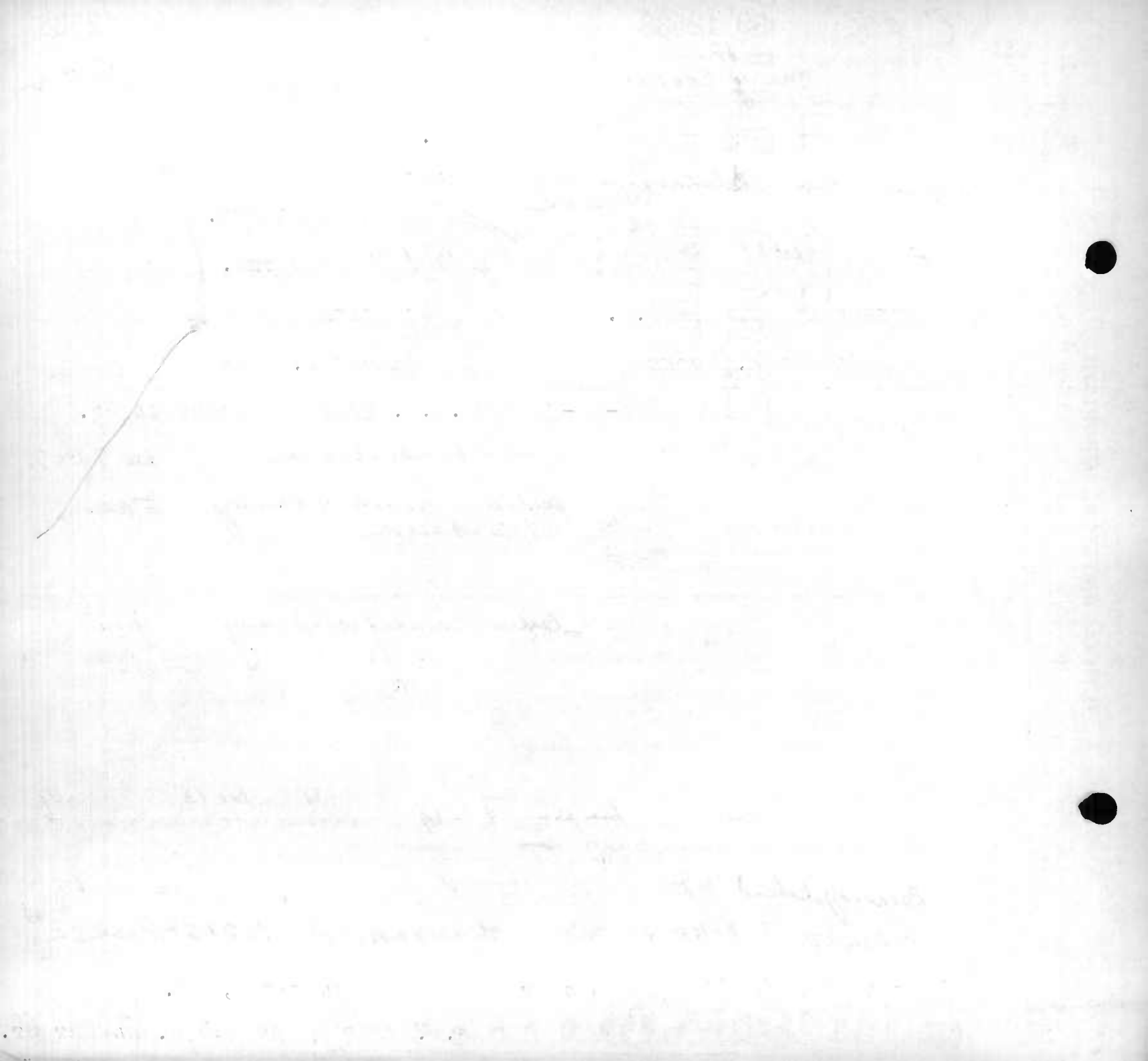
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FUNERAL DIRECTOR: IMPORTANT

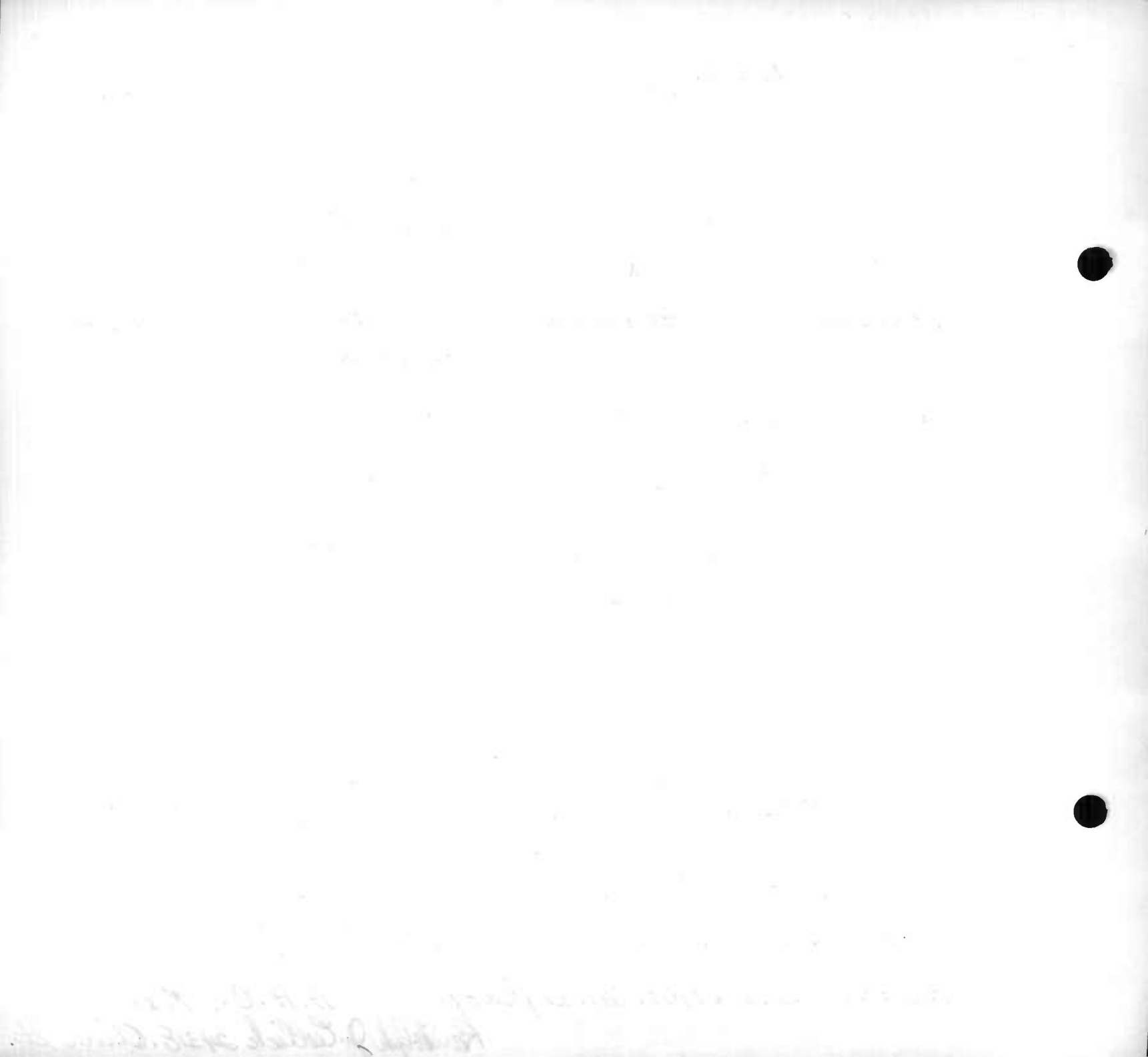
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

C-200		69 12538		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 69 12538	
1. NAME OF DECEASED (Type or Print) <i>Mary Cooke</i>				2. DATE AND HOUR OF DEATH <i>12-13-69</i>   <i>6<sup>15</sup> P mm.</i>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>MD.</i> B. COUNTY <i>2717</i>			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>House in Pines - Belvedere Nursing Home</i>				C. CITY OR TOWN <i>BALTIMORE</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <i>2525 BELVEDERE AVE.</i>							
5. SEX <i>F</i>	6. RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>11/16/1873</i>	9. AGE (In years last birthday) <i>96 YRS.</i>	If Under 1 Yr. Months: Days: Hours: Min.	If Under 24 Hrs. Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>RETIRED</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>R.N.</i>		11. BIRTHPLACE (State or foreign country) <i>VIRGINIA</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>ALFRED W. COOKE</i>				14. MOTHER'S MAIDEN NAME <i>MARTHA C. CARTER</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>213-48-8326</i>		17. INFORMANT <i>GEN. H. C. EVANS</i>		ADDRESS <i>200 LONGWOOD RD.</i>	
18. <i>410.9 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH <i>Acute myocardial infarction</i> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>coronary + general + coronary</i> <i>arterio-sclerosis</i> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>Dec. 9-1969</i> <i>2 years</i>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <i>Coronary + Coronary insufficiency</i>				<i>years</i>			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? Yes or No <i>No</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>Aug.</i> 19 <i>69</i> to <i>Dec 13</i> 19 <i>69</i> , that (I) (we) last saw the deceased alive on <i>Dec 13 -</i> 19 <i>69</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) ( <del>did not</del> ) view the body after death.							
23A. SIGNATURE <i>Bernard J. Cohen MD</i>				23B. DATE SIGNED <i>12-13-69</i>			
23C. PHYSICIAN'S NAME (Type) <i>BERNARD J. COHEN MD</i>				23D. ADDRESS <i>The Maylander Apt - 3501 S. Paul St.</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i>		24B. DATE <i>12/17/69</i>		24C. NAME OF CEMETERY OR CREMATORY <i>GREENMOUNT</i>		24D. LOCATION (City, town, or county) (State) <i>BALTIMORE, MD.</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>DEC 19 1969</i>		25B. NAME OF REGISTRAR <i>Robert E. Fisher</i>		25C. FUNERAL DIRECTOR <i>M. W. MEARS &amp; SON</i>		ADDRESS <i>805 N. CALVERT ST.</i>	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<p><b>69 12539</b></p> <p><b>BALTIMORE CITY HEALTH DEPARTMENT</b></p> <p><b>CERTIFICATE OF DEATH</b></p>		<p>REG. NO. <b>69 12539</b></p>	
<p><b>1. NAME OF DECEASED</b> (Type or Print) <u>Lizzie ELIZABETH PATTERSON</u></p>		<p><b>2. DATE AND HOUR OF DEATH</b> <u>DECEMBER 14, 1969 9:45 A.M.</u></p>	
<p><b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b></p>		<p><b>4. USUAL RESIDENCE</b> (Where deceased lived, if institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>605</u></p>	
<p><b>FULL NAME OF HOSPITAL OR INSTITUTION</b> (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>BALTIMORE CITY HOSPITALS</u> <u>4940 Eastern Avenue</u> <u>Baltimore, Maryland 21224</u></p>		<p><b>C. CITY OR TOWN</b> <u>Baltimore</u></p> <p><b>D. INSIDE CITY LIMITS?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></p> <p><b>E. STREET AND NUMBER</b> <u>232 N. Spring Court 21231</u></p>	
<p><b>5. SEX</b> <u>Female</u></p>	<p><b>6. RACE</b> <u>Negro</u></p>	<p><b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/></p>	<p><b>8. DATE OF BIRTH</b> <u>4-10-97</u></p> <p><b>9. AGE</b> (In years last birthday) <u>72</u></p> <p><b>10. If Under 1 Yr. Months Days</b> <b>11. If Under 24 Hrs. Hours Min.</b></p>
<p><b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Domestic</u></p>		<p><b>10B. KIND OF BUSINESS OR INDUSTRY</b> <u>At home</u></p>	
<p><b>11. BIRTHPLACE</b> (State or foreign country) <u>Holland, Ga.</u></p>		<p><b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u></p>	
<p><b>13. FATHER'S NAME</b> <u>George Fihley</u></p>		<p><b>14. MOTHER'S MAIDEN NAME</b> <u>Price, Rena</u></p>	
<p><b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u></p>		<p><b>16. SOCIAL SECURITY NO.</b> <u>214-44-1523</u></p>	
<p><b>17. INFORMANT</b> <u>BCH: Records Baltimore, Maryland 21224</u></p>		<p><b>ADDRESS</b> <u>4940 Eastern Avenue</u></p>	
<p><b>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>174 X I</u></p>		<p><b>CAUSE OF DEATH</b></p>	
<p><b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p>		<p><b>(A) IMMEDIATE CAUSE</b> <u>Metastatic Carcinoma</u> DUE TO, OR AS A CONSEQUENCE OF: <u>6 YR</u></p> <p><b>(B) CARCINOMA of BREAST</b> DUE TO, OR AS A CONSEQUENCE OF: <u>6 YR</u></p> <p><b>(C)</b> _____</p>	
<p><b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</p>		<p><u>NONE</u></p>	
<p><b>19A. DATE OF OPERATION</b> <u>NO</u></p>		<p><b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b> <u>NO</u></p>	
<p><b>20A. AUTOPSY?</b> (Yes or No) <u>NO</u></p>		<p><b>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</b> <u>NO</u></p>	
<p><b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner) <input type="checkbox"/></p>		<p><b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.) _____</p>	
<p><b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location) _____</p>		<p><b>21D. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) _____</p>	
<p><b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>		<p><b>21F. HOW DID INJURY OCCUR?</b> _____</p>	
<p><b>22. I certify that (1) (this hospital) attended the deceased from <u>NOVEMBER 13, 1969</u> to <u>DECEMBER 14, 1969</u> that (1) (we) last saw the deceased alive on <u>DECEMBER 14, 1969</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.</b></p>			
<p><b>23A. SIGNATURE</b> <u>Michael M. McConnell, M.D.</u></p>		<p><b>23B. DATE SIGNED</b> <u>DECEMBER 14, 1969</u></p>	
<p><b>23C. PHYSICIAN'S NAME</b> (Type) <u>Michael M. McConnell, M.D.</u></p>		<p><b>23D. ADDRESS</b> <u>Baltimore City Hospitals</u> <u>4940 Eastern Avenue Baltimore, Maryland</u></p>	
<p><b>24A. BURIAL CREMATION, REMOVAL</b> (Specify) <u>Burial</u></p>		<p><b>24B. DATE</b> <u>12-18-69 Mt. Calvary Cnty.</u></p>	
<p><b>24C. NAME OF CEMETERY OR CREMATORY</b> <u>B. B. C., Md.</u></p>		<p><b>24D. LOCATION</b> (City, town, or county) (State) <u>2431 E. Oliver St.</u></p>	
<p><b>25A. DATE REC'D BY HEALTH DEPT.</b> <u>DEC 19 1969</u></p>		<p><b>25B. NAME OF REGISTRAR</b> <u>Ralph J. Collick</u></p>	
<p><b>25C. FUNERAL DIRECTOR</b> <u>Ralph J. Collick</u></p>		<p><b>ADDRESS</b> <u>2431 E. Oliver St.</u></p>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <b>69 12540</b>
<b>BIRTH NO.</b> <b>1. NAME OF DECEASED</b> (Type or Print) <b>John L. Haley</b>		<b>69 12540</b> <b>CERTIFICATE OF DEATH</b> <b>2. DATE AND HOUR OF DEATH</b> <b>12-16-69 8:45 A.M.</b>		
<b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b>  <b>FULL NAME OF HOSPITAL OR INSTITUTION</b> <b>(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)</b> <b>00</b> <b>1812 E. Oliver St.</b>		<b>4. USUAL RESIDENCE</b> (Where deceased lived. If institution: residence before admission) <b>A. STATE</b> <b>Maryland</b> <b>B. COUNTY</b> <b>807</b> <b>C. CITY OR TOWN</b> <b>Baltimore</b> <b>E. STREET AND NUMBER</b> <b>1812 E. Oliver St.</b> <b>D. INSIDE CITY LIMITS?</b> <b>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></b>		
<b>5. SEX</b> <b>Male</b>	<b>6. RACE</b> <b>Negro</b>	<b>7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/></b> <b>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></b>	<b>8. DATE OF BIRTH</b> <b>6-7-1892</b>	<b>9. AGE (In years last birthday)</b> <b>77</b>
<b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		<b>10B. KIND OF BUSINESS OR INDUSTRY</b> <b>Steel Co.</b>		
<b>11. BIRTHPLACE</b> (State or foreign country) <b>Warrenton, Va.</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>		
<b>13. FATHER'S NAME</b> <b>UNKNOWN</b>		<b>14. MOTHER'S MAIDEN NAME</b> <b>Martha Murphy</b>		
<b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		<b>16. SOCIAL SECURITY NO.</b> <b>213-17-3488</b>		
<b>17. INFORMANT</b> <b>Mrs. Nellie Haley</b>		<b>ADDRESS</b> <b>1812 E. Oliver St.</b>		
<b>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  <b>II</b> <b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</b>		<b>CAUSE OF DEATH</b> <b>(A) IMMEDIATE CAUSE</b> <b>Arterio sclerotic heart disease</b> <b>DUE TO, OR AS A CONSEQUENCE OF:</b>  <b>(B) Arterio sclerotic</b> <b>DUE TO, OR AS A CONSEQUENCE OF:</b>  <b>(C) Congestive heart failure</b>		
<b>19A. DATE OF OPERATION</b> <b>0</b>		<b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b> <b>20A. AUTOPSY? (Yes or No)</b> <b>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</b>		
<b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner) <input type="checkbox"/>		<b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)		
<b>21D. TIME OF INJURY (APPROX.)</b> <b>12-16-69</b>		<b>21E. INJURY OCCURRED</b> <b>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></b>		
<b>21F. HOW DID INJURY OCCUR?</b>		<b>22. I certify that (I) (this hospital) attended the deceased from 1965 to 1969, and that (I) (we) last saw the deceased alive on 12/15/1969 and that (I) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</b>		
<b>23A. SIGNATURE</b> <b>T. D. Thayer</b>		<b>23B. DATE SIGNED</b> <b>12/19/69</b>		
<b>23C. PHYSICIAN'S NAME (Type)</b> <b>T. D. Thayer</b>		<b>23D. ADDRESS</b> <b>1228 N. Grosvenor St.</b>		
<b>24A. BURIAL CREMATION, REMOVAL (Specify)</b> <b>Burial</b>		<b>24B. DATE</b> <b>12-20-69</b>		
<b>24C. NAME OF CEMETERY OR CREMATORY</b> <b>St. Calvary Cemetery</b>		<b>24D. LOCATION</b> (City, town, or county) (State) <b>Anne Arundel Co., Va</b>		
<b>25A. DATE REC'D BY HEALTH DEPT.</b> <b>DEC 19 1969</b>		<b>25B. NAME OF REGISTRAR</b> <b>Robert E. Taylor</b>		
<b>25C. FUNERAL DIRECTOR</b> <b>Randolph J. Lick</b>		<b>25D. ADDRESS</b> <b>2431 E. Ohio</b>		

John L. Halsey

1021 1/2 Ave

Garfield

1912 Clinton St.

6-1-1874

1812 Clinton St.

1021 1/2 Ave

1021 1/2 Ave

1021 1/2 Ave

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1021 1/2 Ave

1021 1/2 Ave

Cooper's Building

1021 1/2 Ave

1021 1/2 Ave

1021 1/2 Ave

1021 1/2 Ave

1021 1/2 Ave

1021 1/2 Ave

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

69 12541

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>William E. Brown</b>				2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.			
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>00 2017 E. 31st St.</b>				3. DATE PRONOUNCED DEAD Month Day Year Hour <b>12 15 69 11:55 A.M.</b>			
5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>906</b>				C. CITY OR TOWN <b>Balto.</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
6. SEX <b>Male</b>	7. RACE <b>Negro</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		E. STREET AND NUMBER <b>2017 E. 31st St.</b>			
9. DATE OF BIRTH <b>6-7-17</b>		10. AGE (In years lost birthday) <b>52</b>		11. BIRTHPLACE (State or foreign country) <b>Huntersville, N.C.</b>			
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Alphonso Brown</b>		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>C.C.A.</b>			
15. MOTHER'S MAIDEN NAME <b>Pearl King</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		17. SOCIAL SECURITY NO. <b>239-20-9926</b>		18. INFORMANT <b>Effie C. Brown 2017 E. 31st St.</b>	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>444.2</b> <b>Infarction of small intestine</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
20. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (A) <b>superior mesenteric artery thrombosis</b>				(B) <b>due to, or as a consequence of:</b>			
21. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				(C) <b>due to, or as a consequence of:</b>			
20A. DATE OF OPERATION				20B. CONDITION FOR WHICH OPERATION WAS PERFORMED			
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				22F. HOW DID INJURY OCCUR?			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>Russell S. Fisher, M.D.</b>				CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type)				DATE SIGNED <b>12-15-69</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12-21-69</b>		24C. NAME of CEMETERY or CREMATORY <b>Mt. Calvary Cmty</b>		24D. LOCATION (City, town, or county) (State) <b>A.B.C. Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 19 1969</b>		25B. NAME OF REGISTRAR <b>Robert E. Fisher, M.D.</b>		25C. FUNERAL DIRECTOR <b>Randolph J. Collick</b>		ADDRESS	

6-7-77  
Honeywell, Inc. 4-28-  
Pearl River C.C. R.

Special Agent in Charge

U.S. Department of Justice

For information of the Bureau

VALLEY VIEW

VALLEY VIEW

Special Agent in Charge  
U.S. Department of Justice



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

A-615		69 12542		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 69 12542	
BIRTH NO.							
1. NAME OF DECEASED (Type or Print) <u>William Arvin</u>				2. DATE AND HOUR OF DEATH <u>12/17/69</u> <u>8:30</u> PM.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>1703</u>			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>University of Md</u> <u>22 S. Ardena St</u> <u>Baltimore, Md 21201</u>				C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <u>AA 749 W Franklin</u>							
5. SEX <u>M</u>	6. RACE <u>N</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/12/01</u>	9. AGE (In years last birthday) <u>68</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Beth-Steel</u>		11. BIRTHPLACE (State or foreign country) <u>Charlotte Co, VA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Tazwell Arvin</u>				14. MOTHER'S MAIDEN NAME <u>Mary S. Arvin</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No.</u>		16. SOCIAL SECURITY NO. <u>213-09-7288</u>		17. INFORMANT <u>Mrs. Margt. Arvin</u>		ADDRESS <u>910 Russell St</u>	
18. <u>436.9 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc., it means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>Minimal Injury (Poss Embolus)</u>				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>U. Pneumonia,</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>11-13 days</u>	
				(B) <u>Bilateral strokes</u> DUE TO, OR AS A CONSEQUENCE OF:		<u>1 month</u>	
				(C) _____			
MEDICAL CERTIFICATION							
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>11/9/69</u> to <u>12/17</u> 19 <u>69</u> that (I) (we) last saw the deceased alive on <u>12/17</u> 19 <u>69</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Martha</u>				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>12/17/69</u>	
23C. PHYSICIAN'S NAME (Type) <u>Morton Schwartz M.D.</u>				23D. ADDRESS <u>Univ Hospital</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>12/22/69</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Mt. Auburn Cem.</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore Maryland</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>DEC 19 1969</u>		25B. NAME OF REGISTRAR <u>Robert E. Fisher, M.D.</u>		25C. FUNERAL DIRECTOR <u>Morton and Gayle</u>		ADDRESS <u>1701 Laurens St</u>	

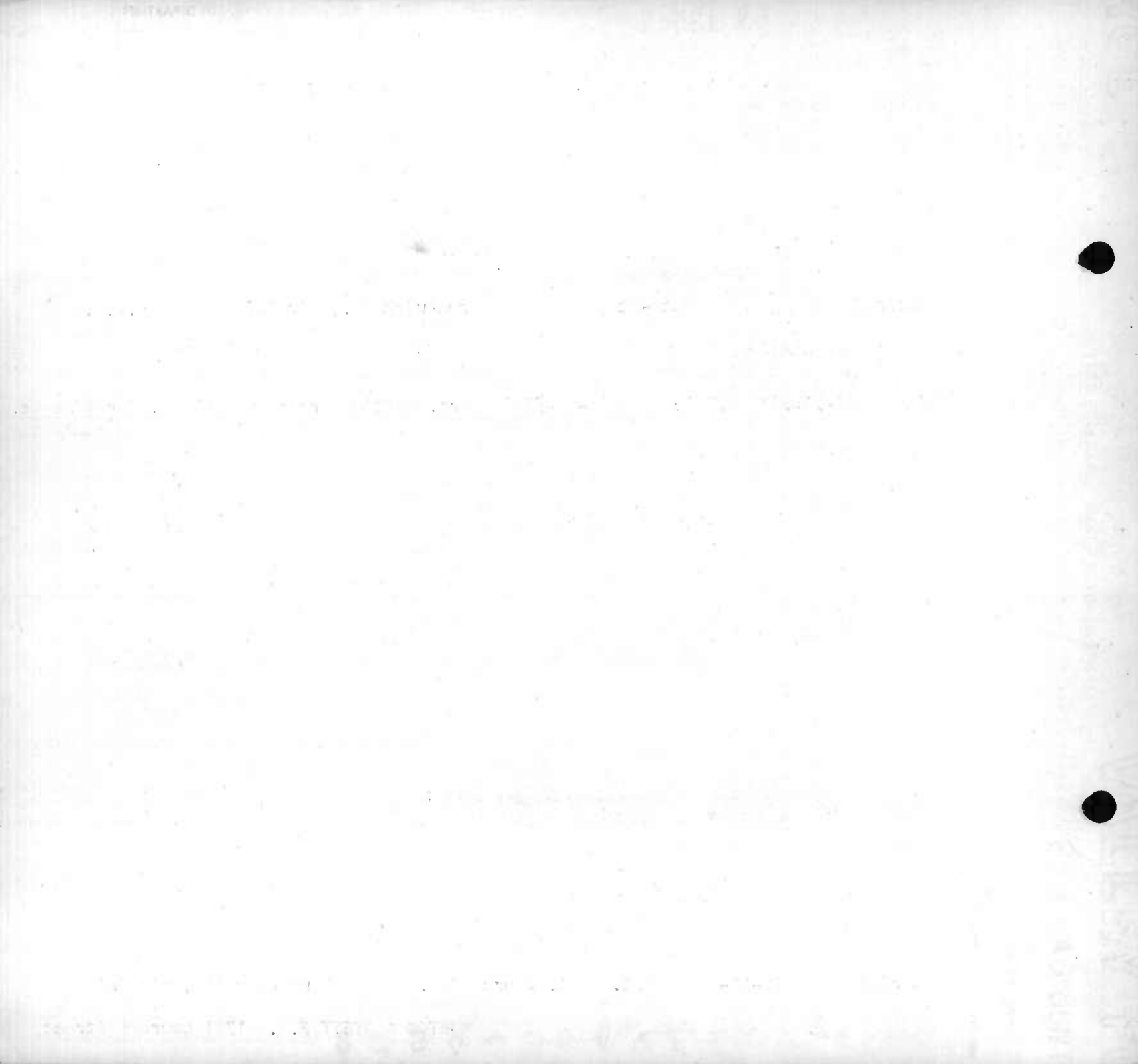


Released as non-med  
by M.E. 12/18/69

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

H-625		69 12543		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 69 12543	
BIRTH NO.				1. NAME OF DECEASED (Type or Print)			
Harrison, Henry C.				2. DATE AND HOUR OF DEATH Dec 18 1969 9 <sup>35</sup> A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 3 The Johns Hopkins Hospital				A. STATE Maryland		B. COUNTY 909	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 1614 Caroline Street			
5. SEX Male		6. RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5/10/94	
9. AGE (In years last birthday) 75		If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired				10B. KIND OF BUSINESS OR INDUSTRY Beth-Steel		11. BIRTHPLACE (State or foreign country) Brunswick Co., Virginia	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Daniel HARRISON				14. MOTHER'S MAIDEN NAME Rhoena Tabb			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes 10/30/17 8/7/19				16. SOCIAL SECURITY NO. 216-09-5761		17. INFORMANT Mrs. Hattie Harrison	
18. 410.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 19A. DATE OF OPERATION 0				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from Dec 18 19 69 to Dec 18 19 69, that (1) (we) lost saw the deceased alive on Dec 18 19 69 and that (n) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Matthew Pocchek MD.				23B. DATE SIGNED Dec 18, 1969			
23C. PHYSICIAN'S NAME (Type) MATTHEW POCCHERK MD.				23D. ADDRESS JHH Johns Hopkins Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial				24B. DATE 12-22-69		24C. NAME OF CEMETERY or CREMATORY 1st. Bapt. Church Cem.	
24D. LOCATION (City, town, or county) (State) Lawrenceville, Virginia							
25A. DATE REC'D BY HEALTH DEPT. DEC 19 1969				25B. NAME OF REGISTRAR Robert E. Taylor, Jr.		25C. FUNERAL DIRECTOR MORTON & DYETT F.H.	
25D. ADDRESS 1701 Laurens Street							



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W-452 69 12544 BALTIMORE CITY HEALTH DEPARTMENT

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO. REG. NO. 69 12544

1. NAME OF DECEASED (Type or Print) <b>ETHEL WILLIAMS</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour <b>December 18, 1969 6:10 A.M.</b>	
4. PLACE IN BALTIMORE, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>1027 Booth Street</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>December 18, 1969 6:10 A.M.</b>	
6. SEX <b>Female</b>		7. RACE <b>Negro</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>1803</b>	
9. DATE OF BIRTH <b>1-12-1929</b>		10. AGE (In years lost birthday) <b>40</b>	
11. BIRTHPLACE (State or foreign country) <b>Yemassee, S. Carolina</b>		12. CITIZEN OF <b>U.S.A.</b>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		14B. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No.</b>		17. SOCIAL SECURITY NO.	
18. INFORMANT <b>Mrs. Delores Ford</b>		ADDRESS <b>1035 Orleans St. Apt 10-C</b>	
19. <b>571.8 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>Fatty metamorphosis of liver</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
		(B) DUE TO, OR AS A CONSEQUENCE OF:	
		(C) DUE TO, OR AS A CONSEQUENCE OF:	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL EXAMINER'S NAME (Type) <b>Charles S. Springate, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>December 18, 1969</b>	
ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12-21-69</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Mt. Olive Ch. Cem.</b>		24D. LOCATION (City, town, or county) (State) <b>Hardeeville, South Carolina</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 19 1969</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor, M.D.</b>	
25C. FUNERAL DIRECTOR <b>MORTON &amp; DYETT F.H.</b>		ADDRESS <b>1701 Laurens Street</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 69 12545	
H-400		69 12545		CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Elsie T. Holly		12-18-69 9:55 A M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		A. STATE	
		MD.		8. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN	
3133 Leeds ST.		00		BALTO.	
				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER	
				3133 Leeds ST.	
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years lost birthday)	10. Under 1 Yr. Months Days
F	Negro	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	12-16-1890	79	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Retired				BALTO. MD.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
LARKIN B. THOMAS		SUSAN WILLIAMS		U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT	
No		216-01-0792		ROSE WILLIAMS	
				ADDRESS	
				3133 Leeds ST	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		Cerebral Occlusion Several Hrs	
ANTECEDENT CAUSES		(B) DUE TO, OR AS A CONSEQUENCE OF:		Cerebral Hemorrhage Several days	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) Hypertensive Cardiovascular Dis. Unknown			
II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (the hospital) attended the deceased from 12-10-1969 to 12-18-1969, that (I) (we) last saw the deceased alive on 12-17-1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Richard H. Hunt				12/18/69	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
Richard H. Hunt				1607 W. Mulberry St. Balto. Md	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY	
Burial		12-22-69		Arbutus Mem Park Arbutus Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
DEC 19 1969		Robert E. Taylor, M.D.		Wesley Thomas Jr. 1422 Edmondson Ave	

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 69 12546	
BIRTH NO. 69 12546		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Agnes K. Rider		2. DATE AND HOUR OF DEATH 12/17/69 8:30 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  1910 E. Belvedere Ave.		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 2758 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 1910 E. Belvedere Ave.			
5. SEX F.	6. RACE W.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 13, 1896	9. AGE (In years last birthday) 73	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME James Brennen		14. MOTHER'S MAIDEN NAME Mary Murphy	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 217-22-2967 D		17. INFORMANT ADDRESS Mr. Richard Rider 6605 Sherwood Rd. 21212	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: ACUTE CORONARY OCCLUSION (B) HYPERTENSIVE ARTERIOSCLEROTIC HEART DISEASE. UNKNOWN (C) ...		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH UNKNOWN	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from April 15 1969 to Dec. 18 1969, that (I) (we) last saw the deceased alive on Oct 31 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Marcio M. Menendez, M.D.		23B. DATE SIGNED 12-18-69		23C. PHYSICIAN'S NAME (Type) Marcio M. Menendez Md.	
23D. ADDRESS 5820 York Road Balto. Md.		24A. BURIAL CREMATION, REMOVAL (Specify) Burial			
24B. DATE 12/22/69		24C. NAME of CEMETERY or CREMATORY Baltimore National Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore Maryland	
25A. DATE REC'D BY HEALTH DEPT. DEC 22 1969		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.		25C. FUNERAL DIRECTOR ADDRESS Leonard J. Ruck Inc. Balto. Md.	



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BALTIMORE CITY HEALTH DEPARTMENT

69 12547 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

69 12547

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>Stephen Badalato</b> <del>Stephen Badalato</del>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour <b>12 17 69 2:45 a.m.</b>	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>Union Memorial Hospital D.O.A.</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>December 17, 1969 2:45 a.m.</b>	
6. SEX <b>Male</b>		7. RACE <b>White</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Balto.</b>	
9. DATE OF BIRTH <b>April 5, 1949</b>		10. AGE (In years last birthday) <b>20</b>	
11. BIRTHPLACE (State or foreign country) <b>West Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpet Installer</b>		14B. KIND OF BUSINESS OR INDUSTRY	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		17. SOCIAL SECURITY NO.	
13. FATHER'S NAME <b>Philip J Badalato</b>		15. MOTHER'S MAIDEN NAME <b>Harriet L Norman</b>	
18. INFORMANT <b>Mr Philip J Badalato</b>		ADDRESS <b>Same</b>	
19. CAUSE OF DEATH <b>E818.01</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE <b>Multiple injuries</b> DUE TO, OR AS A CONSEQUENCE OF:	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) DUE TO, OR AS A CONSEQUENCE OF:	
(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, public bldg., etc.) <b>Street</b>	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>Hillen Rd. S of Hartsdale Rd.</b>		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
22D. TIME OF INJURY (APPROX.) <b>12 17 69 1:45 a.m.</b>		22F. HOW DID INJURY OCCUR? <b>Subject driver in auto accident, thrown from car</b>	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
ACTUAL SIGNATURE <b>Isidore Mihalakis, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type)		ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12/20/69</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Gardens Of Faith</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 22 1969</b>		25B. NAME OF REGISTRAR <b>Robert E. Fisher, M.D.</b>	
25C. FUNERAL DIRECTOR <b>Leonard J. Rock Inc.</b>		ADDRESS <b>Baltimore, Maryland</b>	

Baltimore, Maryland

12/20/50

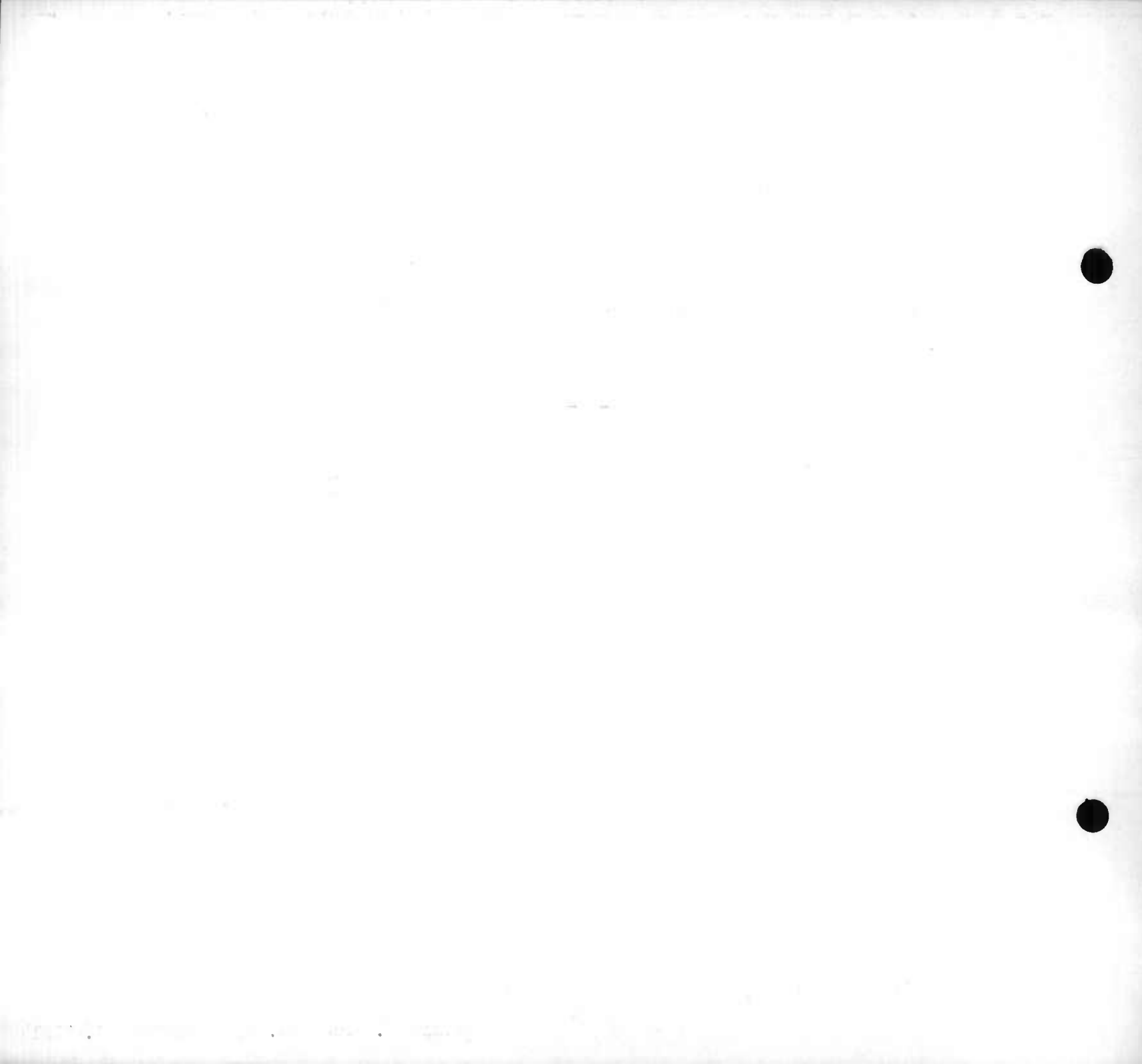
12/20/50

Account 4 Inc. Inc. Baltimore, Maryland

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

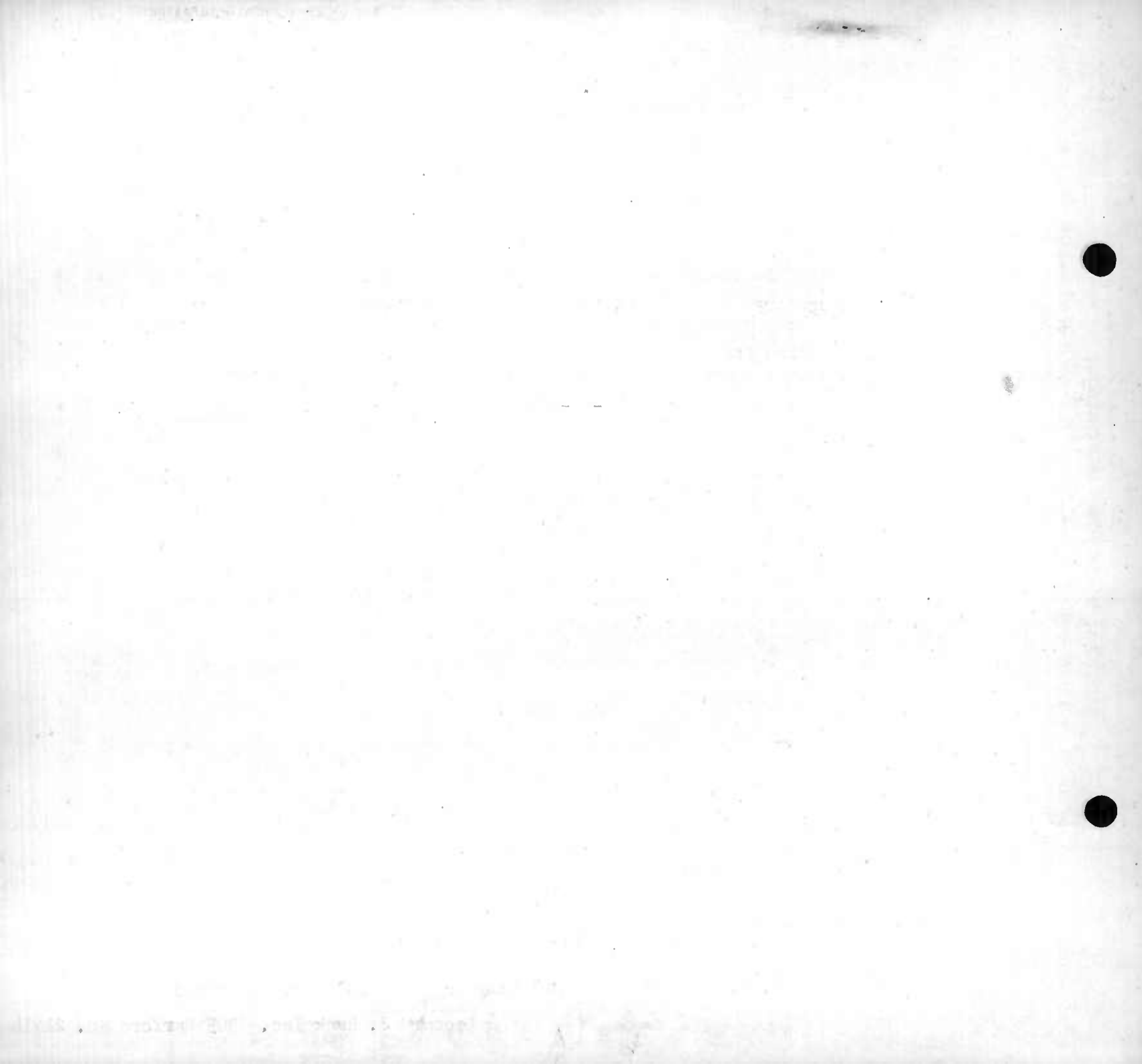
BIRTH NO. 69 12543		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 69 12548	
1. NAME OF DECEASED (Type or Print) WILLIAM H. WISE		2. DATE AND HOUR OF DEATH 12/17/69 3 30 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION UNIV. Md. 38 BART Md.		4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE Md. B. COUNTY Dorchester 5900 C. CITY OR TOWN CAMBRIDGE D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER PAW PAW PT. Rd.			
5. SEX m	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/1/1900	9. AGE (In years last birthday) 69	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ENGINEER		10B. KIND OF BUSINESS OR INDUSTRY Martin Company		11. BIRTHPLACE (State or foreign country) Md.	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME CHARLES WISE		14. MOTHER'S MAIDEN NAME LILLIE FROME	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) NO		16. SOCIAL SECURITY NO. 214-01-3135		17. INFORMANT MRS. ETHEL WISE	
18. 200.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: RETICULUM CELL SARCOMA (B) PERFORATION BOWEL (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 13 MONTHS 4 days	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 12/12 1969 to 12/17 1969 that (I) (we) last saw the deceased alive on 12/16 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Howard Wallach MD		23B. DATE SIGNED 12/17/69		23C. PHYSICIAN'S NAME (Type) HOWARD WALLACH MD	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/20/69		24C. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery	
24D. LOCATION (City, town, or county) Baltimore Maryland		24E. DATE REC'D BY HEALTH DEPT. DEC 22 1969		24F. NAME OF REGISTRAR R. E. Feltz, Md.	
24G. FUNERAL DIRECTOR Leonard J. Buck Inc.		24H. ADDRESS 5305 Harford Rd. 21214		24I. VS 150-REV. 1/1/68	



# FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT									
69 12549 CERTIFICATE OF DEATH									
1. NAME OF DECEASED (Type or Print)					2. DATE AND HOUR OF DEATH				
Finnegan, Margaret E.					12/16/69 8:50 A.M.				
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)					A. STATE B. COUNTY				
The Johns Hopkins Hospital					Maryland 2768				
					C. CITY OR TOWN		D. INSIDE CITY LIMITS?		
					Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
					E. STREET AND NUMBER				
					902 Woodson Road, Apt. E				
5. SEX		6. RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)	
Female		White				6/02/09		60	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)					10B. KIND OF BUSINESS OR INDUSTRY				
Private Secretary					Deniseal				
11. BIRTHPLACE (State or foreign country)					12. CITIZEN OF WHAT COUNTRY?				
Maryland					USA				
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME				
Charles Finnegan					Mary E. Fraunholz				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)					16. SOCIAL SECURITY NO.				
No					213-01-0076				
17. INFORMANT					ADDRESS				
Mrs. Eugenia M. Krebs - Balto. Md.									
18. CAUSE OF DEATH									
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH									
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)									
ANTECEDENT CAUSES									
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.									
I									
CAUSE OF DEATH									
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: METASTATIC OVARIAN Ca 2 yrs.									
(B) DUE TO, OR AS A CONSEQUENCE OF:									
(C) DUE TO, OR AS A CONSEQUENCE OF:									
II									
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).									
19A. DATE OF OPERATION					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				
2									
20A. AUTOPSY? (Yes or No)					20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
Yes					NO				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)					21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)									
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)					21E. INJURY OCCURRED				
					While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				
21F. HOW DID INJURY OCCUR?									
22. I certify that (I) (this hospital) attended the deceased from 19 to 19, that (I) (we) lost saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE					23B. DATE SIGNED				
William L. Horvath M.D.					12/16/69				
23C. PHYSICIAN'S NAME (Type)					23D. ADDRESS				
WILLIAM L. HORVATH M.D.					JOHNS HOPKINS HOSP. BALTO.				
24A. BURIAL CREMATION, REMOVAL (Specify)					24B. DATE				
Burial					12/19/69				
24C. NAME OF CEMETERY or CREMATORY					24D. LOCATION (City, town, or county) (State)				
New Cathedral Cemetery					Baltimore Maryland				
25A. DATE REC'D BY HEALTH DEPT.					25B. NAME OF REGISTRAR				
DEC 22 1969					Robert E. Fisher				
25C. FUNERAL DIRECTOR					ADDRESS				
Leonard J. Ruck Inc.					5305 Harford Rd. 21214				





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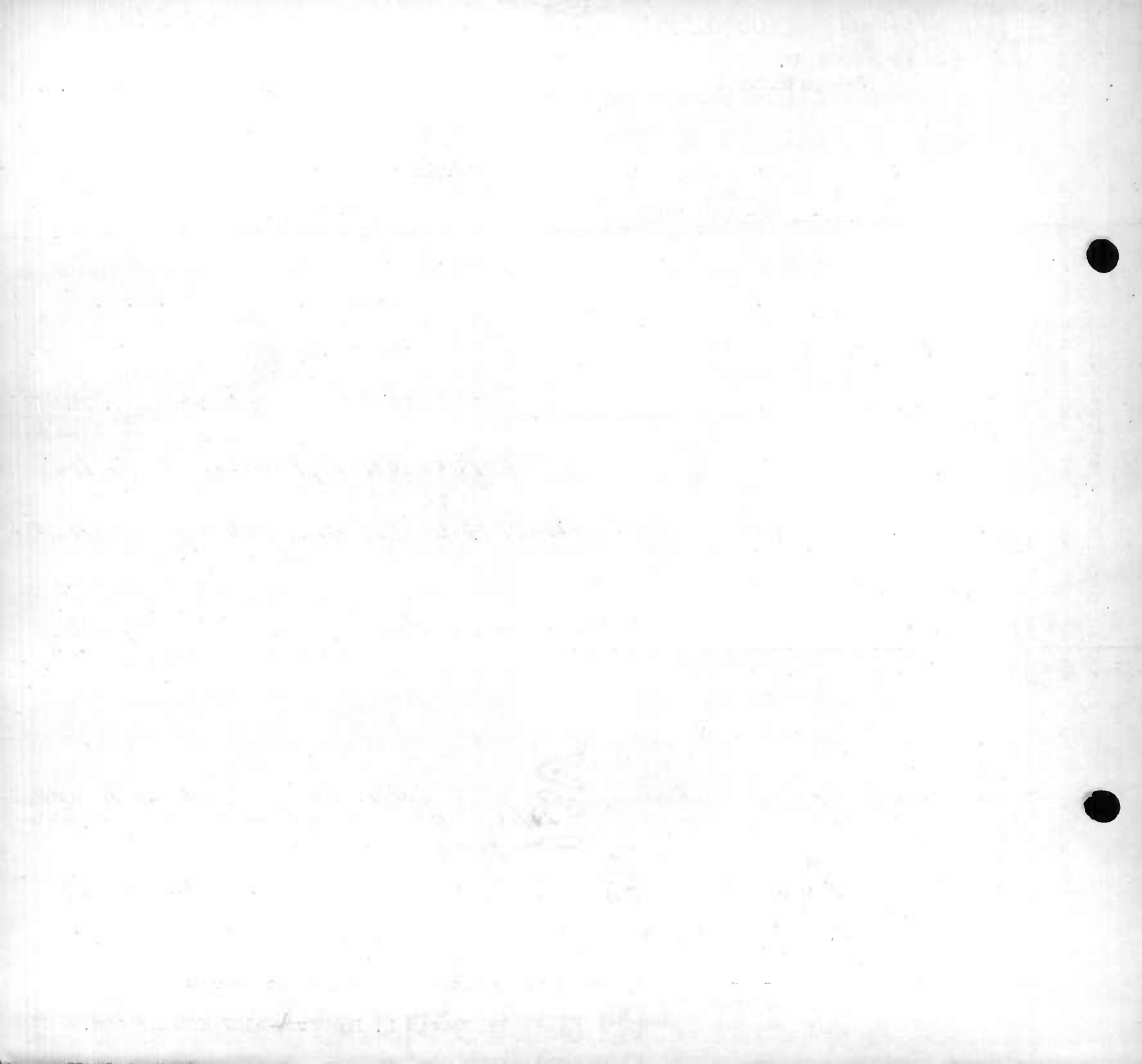
B-350		69 12550		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 69 12550	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) <b>MRS ANNA B. BUTTON.</b>			
2. DATE AND HOUR OF DEATH <b>Dec. 17<sup>th</sup> 1969 1:00 A.M.</b>							
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <b>MARYLAND GENERAL HOSPITAL</b>				4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b>			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>MARYLAND GENERAL HOSPITAL</b>				C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <b>Female</b> 6. RACE <b>White</b>				7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>12/23/1887</b> 9. AGE (In years last birthday) <b>81</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>GEORGE J. HERBERT</b>				14. MOTHER'S MAIDEN NAME <b>ANNA STREB</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>217-24-8096</b>		17. INFORMANT <b>MR. C. EARL BUTTON</b>	
18. <b>412.3 I</b> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>(A) IMMEDIATE CAUSE</b> <b>Coronary Artery</b> <b>(B) DUE TO, OR AS A CONSEQUENCE OF:</b> <b>Coronary Insufficiency</b> <b>(C) Arteriosclerotic Cardiovascular Disease</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>11/12/1969</b> to <b>12/17/1969</b> that (I) (we) last saw the deceased alive on <b>12/17/1969</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Mohamed Ali Ibrahim</b>				23B. DATE SIGNED <b>12-17-1969</b>			
23C. PHYSICIAN'S NAME (Type) <b>M.S. AL-TBRAHIM, M.D., Ch.B.</b>				23D. ADDRESS <b>Maryland General Hospital</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>12/20/69</b>		24C. NAME OF CEMETERY or CREMATORY <b>Holy Redeemer Cem.</b>		24D. LOCATION (City, town, or county) (State) <b>Balto. Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 22 1969</b>		25B. NAME OF REGISTRAR <b>Robert E. [Signature]</b>		25C. FUNERAL DIRECTOR <b>LEONARD J. RUCK INC.</b>		ADDRESS <b>BALTO. MD.</b>	



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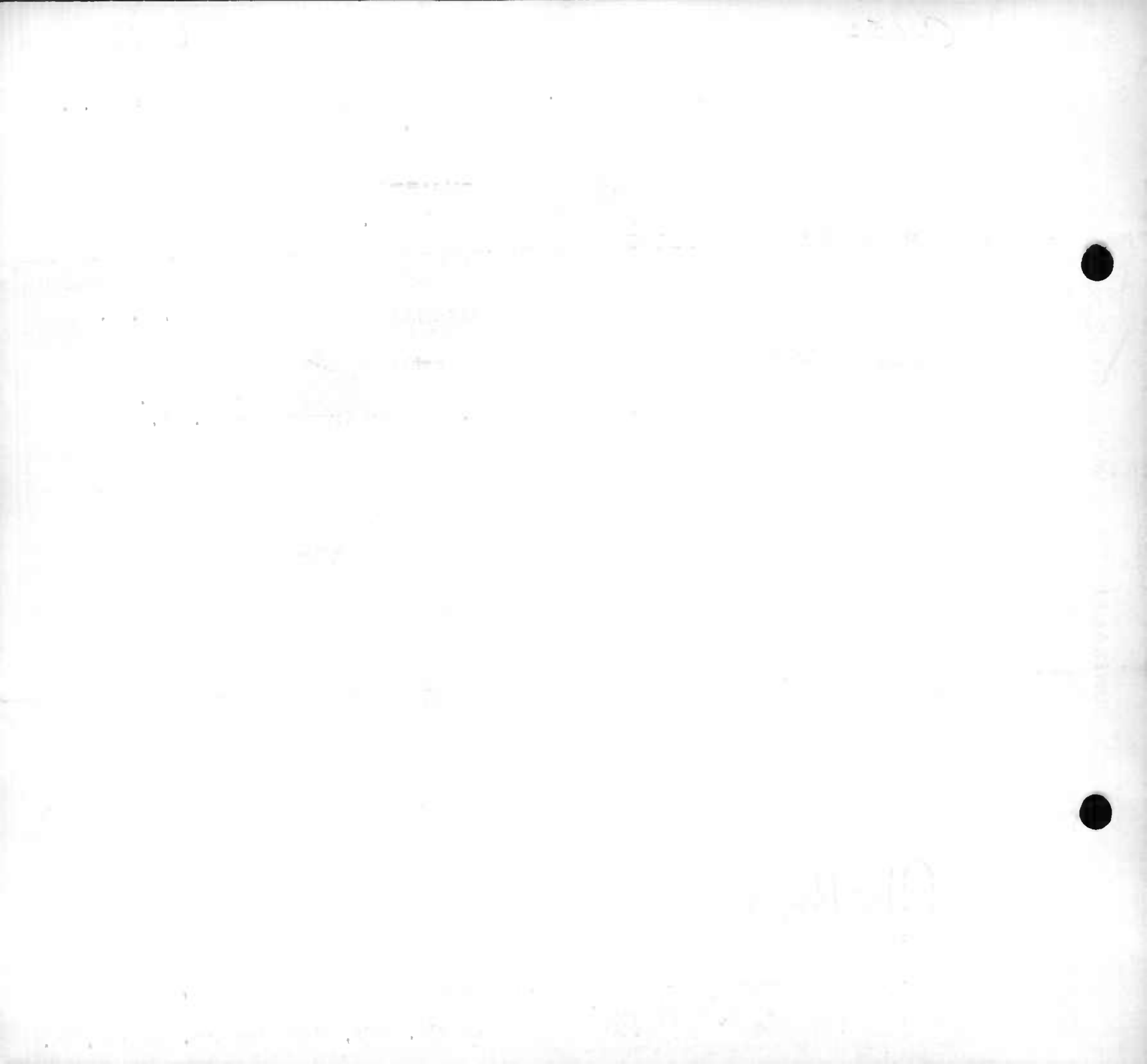
<div style="display: flex; justify-content: space-between;"> <span>M-240</span> <span>69 12551</span> <span>BALTIMORE CITY HEALTH DEPARTMENT</span> </div> <div style="display: flex; justify-content: space-between;"> <span>CERTIFICATE OF DEATH</span> <span>REG. NO. 69 12551</span> </div>	
BIRTH NO. _____	
1. NAME OF DECEASED <span style="float: right;">O.</span> (Type or Print) <b>Joseph Maxwell</b>	
2. DATE AND HOUR OF DEATH <div style="display: flex; justify-content: space-between;"> <span>12/18/69</span> <span>8:25 A.M. M.</span> </div>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>Jenkins Memorial Hospital</b> <b>1000 Caton Avenue</b> <b>Baltimore, Maryland 21229</b>	
4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission) A. STATE <b>MD</b> B. COUNTY _____	
C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <b>2508 Parktrail Rd.</b>	
5. SEX <b>Male</b>	6. RACE <b>White</b>
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 19, 1889</b>
9. AGE (In years last birthday) <b>80</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Plumber</b>	
10B. KIND OF BUSINESS OR INDUSTRY _____	
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>John Maxwell</b>	
14. MOTHER'S MAIDEN NAME <b>Sarah Conklin</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Unknown</b>	
16. SOCIAL SECURITY NO. <b>212-10-1246-A</b>	
17. INFORMANT <b>Medical Records</b> ADDRESS <b>Jenkins Memorial Hos. 1000 Caton Ave. 21229</b>	
18. <b>5192 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.	
CAUSE OF DEATH (A) IMMEDIATE CAUSE <b>Pneumonia, terminal.</b> DUE TO, OR AS A CONSEQUENCE OF:  (B) <b>chronic obstructive airway disease</b> DUE TO, OR AS A CONSEQUENCE OF:  (C) _____	
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>12 hrs</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>Atherosclerotic Heart Disease</b>	
19A. DATE OF OPERATION <b>0</b> 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED _____	
20A. AUTOPSY? (Yes or No) _____ 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? _____	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>	
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) _____	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) _____	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR? _____	
22. I certify that <b>(M)</b> (this hospital) attended the deceased from <b>July 18, 1967</b> to <b>Dec 18, 1969</b> , that <b>(M)</b> (we) last saw the deceased alive on <b>12/18/69</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.	
23A. SIGNATURE <b>J. Raymond Gladue</b> Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>	
23B. DATE SIGNED <b>12-18-69</b>	
23C. PHYSICIAN'S NAME (Type) <b>J. Raymond Gladue</b>	
23D. ADDRESS _____	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	
24B. DATE <b>12-22-1969</b>	
24C. NAME of CEMETERY or CREMATORY <b>Holy Redeemer Cemetery</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 22 1969</b>	
25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>	
25C. FUNERAL DIRECTOR <b>Howard H. Hubbard</b> ADDRESS <b>4107 Wilkens Ave. 21229</b>	



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<div style="display: flex; justify-content: space-between;"> <span>C-652</span> <span>69 12552</span> <span>BALTIMORE CITY HEALTH DEPARTMENT</span> </div> <div style="display: flex; justify-content: space-between;"> <span>BIRTH NO.</span> <span>CERTIFICATE OF DEATH</span> <span>REG. NO. 69 12552</span> </div>			
1. NAME OF DECEASED (Type or Print) <b>CROUNSE, MRS. MYRTLE E.</b>		2. DATE AND HOUR OF DEATH <b>DEC. 18, 1969 9:50 A.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>CHURCH HOME AND HOSPITAL 100 NORTH BROADWAY BALTIMORE, MARYLAND 21231</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md.</b> & COUNTY <b>Baltimore Co.</b> <b>BOX 500 RT. 10, 21219</b> C. CITY OR TOWN <b>Sparrows Point</b> INSIDE CITY LIMITS? <b>BALTIMORE, MARYLAND</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER <b>Box 500 Rt. #10</b>	
5. SEX <b>FEMALE</b>	6. RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9/1/1900</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  <b>HOUSEWIFE</b>		9. AGE (in years last birthday) <b>69</b>	11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>
13. FATHER'S NAME <b>WILLIAM Leishear</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>215 22 0927</b>	
17. INFORMANT <b>Mr. Theodore Crouse</b>		ADDRESS <b>Box 500 Rt. #10 Balto. Md. 21219</b>	
18. <b>153.8 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE <b>CARDIO RESPIRATORY</b> DUE TO, OR AS A CONSEQUENCE OF: <b>ARREST.</b> <b>RENAL FAILURE</b> (B) <b>CANCER OF COLON</b> DUE TO, OR AS A CONSEQUENCE OF: (C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) <b>No</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>12-1-1969</b> 19 to <b>12-18-</b> 19 <b>69</b> that (I) (we) last saw the deceased alive on <b>12-18-</b> 19 <b>69</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <i>[Signature]</i>		23B. DATE SIGNED <b>12/18/69</b>	
23C. PHYSICIAN'S NAME (Type) <b>CARLOS A. LEA PLAZA</b>		23D. ADDRESS <b>5518 D SARRIL RD 21206 BALTO</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12/22/69</b>	
24C. NAME OF CEMETERY OR CREMATORY <b>Lake View Memorial Park</b>		24D. LOCATION (City, town, or county) (State) <b>Sykesville, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 22 1969</b>		25B. NAME OF REGISTRAR <b>John J. Dudley</b>	
25C. FUNERAL DIRECTOR <b>John J. Dudley</b>		ADDRESS <b>7922 Wise Ave. Dundalk, Md.</b>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

69 12553		BALTIMORE CITY HEALTH DEPARTMENT		69 12553	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Emma Kappel		12/16/69 2:25 P M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION BALTIMORE CITY HOSPITALS 4940 Eastern Avenue Baltimore, Maryland 21224		A. STATE Maryland, Baltimore Co.		B. COUNTY 5300	
C. CITY OR TOWN Dundalk		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
E. STREET AND NUMBER 72 York Way 21222 005					
5. SEX Female	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-20-83	9. AGE (In years last birthday) 86	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At home
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Ferdinand F. Haase		14. MOTHER'S MAIDEN NAME Alice Ann Ash			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT BCH-Records 4940 Eastern Avenue Baltimore, Maryland 21224	
18. <u>410.9</u> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: MYOCARDIAL INFARCTION CORONARY ARTERY DISEASE (B) Atherosclerotic Cardiovascular heart Disease DUE TO, OR AS A CONSEQUENCE OF: (C) <u>Coronary Artery</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>12/19</u> 19 <u>69</u> to <u>12/16</u> 19 <u>69</u> that (I) (we) last saw the deceased alive on <u>12/16</u> 19 <u>69</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Arnold J. Levinson MD.		23B. DATE SIGNED 12-16-69		23C. PHYSICIAN'S NAME (Type) Arnold J. Levinson MD.	
23D. ADDRESS 4940 Eastern Avenue BCH-Baltimore, Maryland 21224					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/19/69		24C. NAME OF CEMETERY or CREMATORY Baltimore National	
24D. LOCATION Baltimore, Md.					
25A. DATE REC'D BY HEALTH DEPT. DEC 22 1969		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR Gullrich Funeral Home, Dundalk, Md.	





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<div style="display: flex; justify-content: space-between;"> <span><b>Z-100</b></span> <span><b>69 12554</b></span> </div>		<b>BALTIMORE CITY HEALTH DEPARTMENT</b> <b>CERTIFICATE OF DEATH</b>		<b>REG. NO. 69 12554</b>	
<b>1. NAME OF DECEASED</b> (Type or Print) <b>ZEPP GREGORY JOSEPH</b>			<b>2. DATE AND HOUR OF DEATH</b> <b>12-17-69</b>		
<b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b>  <b>UNIVERSITY OF MARYLAND HOSPITAL.</b>			<b>4. USUAL RESIDENCE</b> (Where deceased lived, if institution; residence before admission) <b>A. STATE</b> <b>Maryland</b> <b>B. COUNTY</b> <b>BALTO.</b>		
<b>5. SEX</b> <b>M</b> <b>6. RACE</b> <b>W</b> <b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input checked="" type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>			<b>8. DATE OF BIRTH</b> <b>11-21-69</b> <b>9. AGE</b> (In years lost birthday) <b>28</b> <b>10. UNDER 1 Yr. Months</b> <b>26</b> <b>11. UNDER 24 Hrs. Hours</b> <b>26</b> <b>12. UNDER 24 Hrs. Min.</b>		
<b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)			<b>10B. KIND OF BUSINESS OR INDUSTRY</b>		
<b>11. BIRTHPLACE</b> (State or foreign country) <b>Maryland</b>			<b>12. CITIZEN OF WHAT COUNTRY</b> <b>U.S.A.</b>		
<b>13. FATHER'S NAME</b> <b>Edgar N ZEPP III</b>			<b>14. MOTHER'S MAIDEN NAME</b> <b>Rosemary WALTERS</b>		
<b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) <b>No</b>			<b>16. SOCIAL SECURITY NO.</b> <b>NONE</b>		
<b>17. INFORMANT</b> <b>Edgar ZEPP III</b>			<b>ADDRESS</b> <b>716 Brookwood Rd BALTO. Md 21229</b>		
<b>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>747.4 I</b> <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			<b>CAUSE OF DEATH</b> <b>(A) IMMEDIATE CAUSE</b> <b>Congestive heart failure</b> <b>DUE TO, OR AS A CONSEQUENCE OF:</b> <b>(B) Congenital anomalous Pulmonary</b> <b>DUE TO, OR AS A CONSEQUENCE OF:</b> <b>(C) Venous drainage</b>		
<b>19A. DATE OF OPERATION</b> <b>2</b>			<b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b>		
<b>20A. AUTOPSY?</b> (Yes or No) <b>YES</b>			<b>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</b>		
<b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (Indify medical examiner) <input type="checkbox"/>			<b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		
<b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)			<b>21D. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (Approx.)		
<b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			<b>21F. HOW DID INJURY OCCUR?</b>		
<b>22. I certify that (I) (this hospital) attended the deceased from 12-16-69 to 17-10-1969 that (I) (we) last saw the deceased alive on 17-10-1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</b>					
<b>23A. SIGNATURE</b>			<b>23B. DATE SIGNED</b> <b>12-17-69</b>		
<b>23C. PHYSICIAN'S NAME</b> (Type) <b>Dr. BAIG</b>			<b>23D. ADDRESS</b> <b>University Hospital</b>		
<b>24A. BURIAL CREMATION, REMOVAL</b> (Specify) <b>BURIAL</b>		<b>24B. DATE</b> <b>12-19-69</b>		<b>24C. NAME OF CEMETERY OR CREMATORY</b> <b>ST LOUIS CEM.</b>	
<b>24D. LOCATION</b> (City, town, or county) (State) <b>CLARKSVILLE, HOWARD MD.</b>		<b>25A. DATE REC'D BY HEALTH DEPT.</b> <b>DEC 22 1969</b>		<b>25B. NAME OF REGISTRAR</b> <b>Robert E. Taylor, Md.</b>	
<b>25C. FUNERAL DIRECTOR</b> <b>Edgar ZEPP III</b>		<b>25D. ADDRESS</b> <b>Ellicott City, Md 21043</b>		<b>25E. SIGNATURE</b>	

1785

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

K-625		69 12555		BALTIMORE CITY HEALTH DEPARTMENT		69 12555	
BIRTH NO.				REG. NO.			
1. NAME OF DECEASED (Type or Print) <b>KRIKSCUNAS, AMELIA</b>				2. DATE AND HOUR OF DEATH <b>DECEMBER 16, 1969 11:20A M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  <b>ST. AGNES HOSPITAL</b>				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MARYLAND</b> CITY <b>CITY</b> C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>1810 SPENCE ST 21230</b>			
5. SEX <b>FEMALE</b>	6. RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>02/07/93</b>	9. AGE (In years lost birthday) <b>76</b>	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED</b>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>LITHUANIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S. CITIZEN</b>
13. FATHER'S NAME <b>JOSEPH RIMAS</b>				14. MOTHER'S MAIDEN NAME			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) <b>NONE</b>		16. SOCIAL SECURITY NO. <b>216-09-2494</b>		17. INFORMANT <b>ST. AGNES HOSPITAL RECORDS</b>			
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>DISSEMINATED ADENO-CARCINOMA RECTUM</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>?</b>			
19A. DATE OF OPERATION <b>12/10/69</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>CARCINOMA</b>		20A. AUTOPSY? (Yes or No) <b>NONE</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>NOVEMBER 11 1969</b> to <b>DECEMBER 16 1969</b> that (I) (we) last saw the deceased alive on <b>DECEMBER 16 1969</b> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>W. C. Signor M.D.</b>				23B. DATE SIGNED <b>12/16/69</b>		23C. PHYSICIAN'S NAME (Type) <b>WILLIAM SIGNOR M.D.</b>	
23D. ADDRESS <b>BALTIMORE MARYLAND 21229 ST. AGNES HOSP; CATON &amp; WILKENS AVES.</b>							
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12-20-69</b>		24C. NAME of CEMETERY or CREMATORY <b>Most Holy Redeemer Cem</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 22 1969</b>		25B. NAME OF REGISTRAR <b>John E. Kelly, M.D.</b>		25C. FUNERAL DIRECTOR <b>Thomas J. Kelly Inc 1600 Hollins Balto</b>			

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Sgt. A. J. [unclear]

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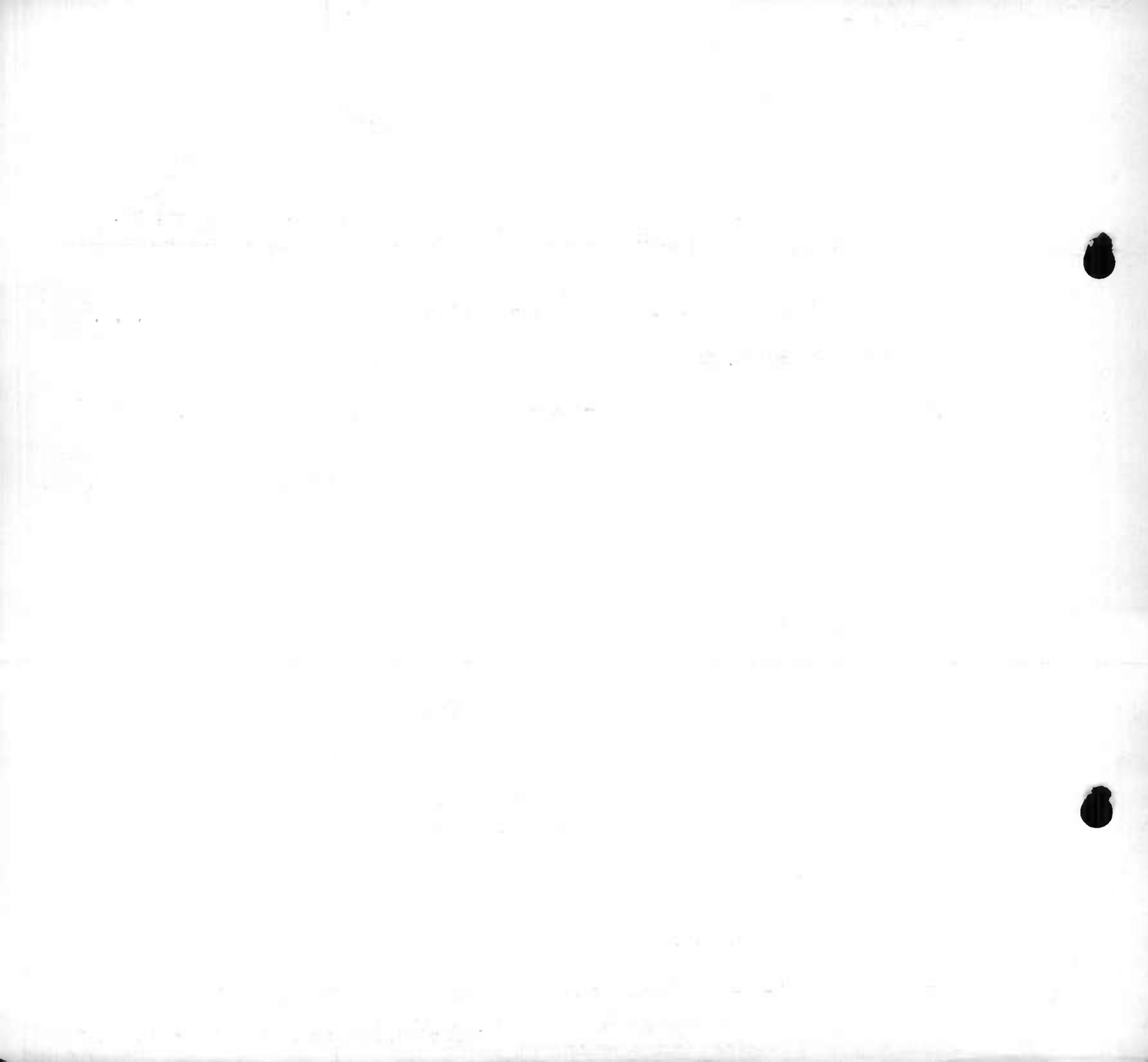
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## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

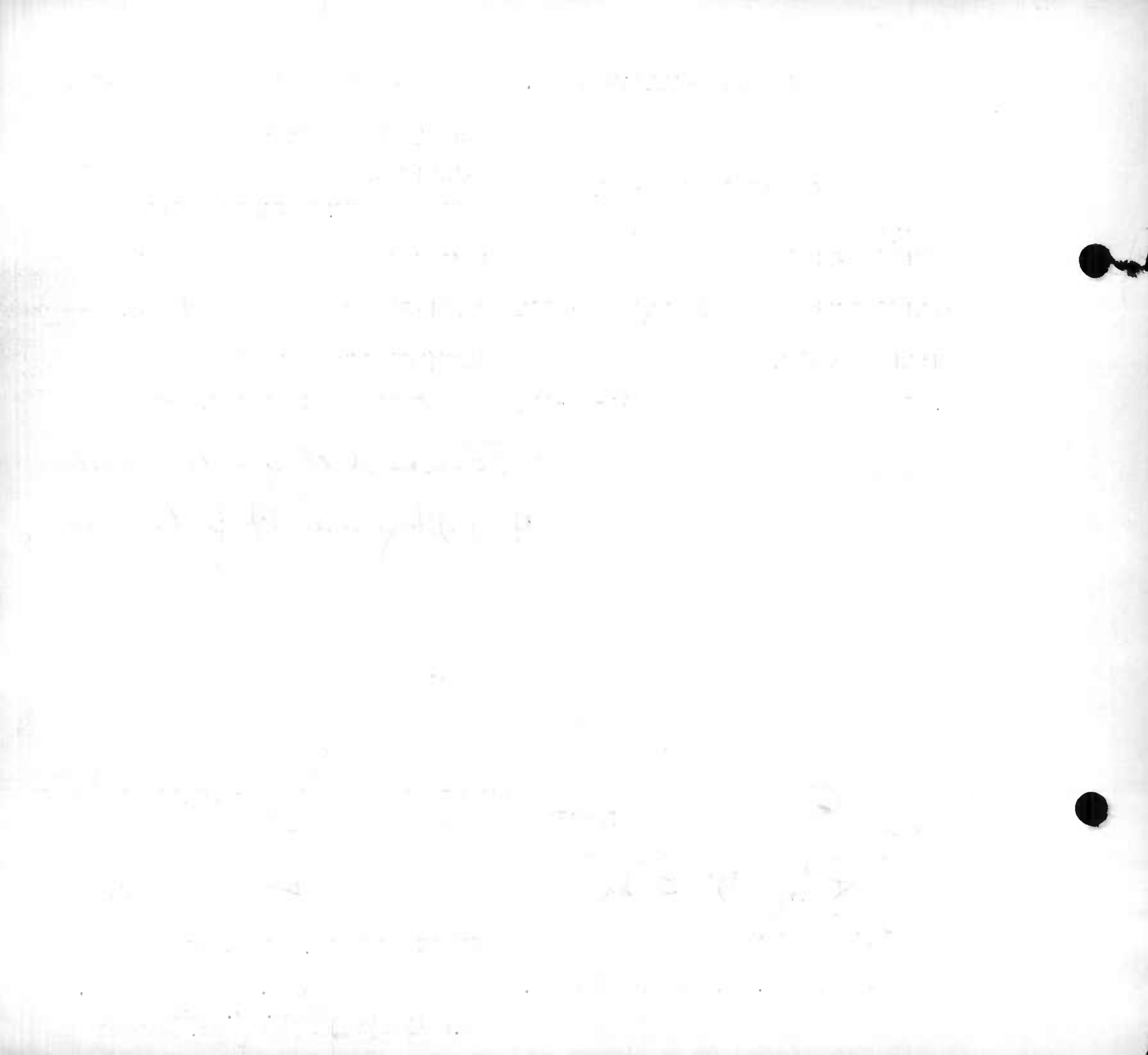
L-625		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 69 12556	
69 12556		CERTIFICATE OF DEATH			
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>LARKINS, ROBERT LEE</b>		2. DATE AND HOUR OF DEATH <b>DECEMBER 15, 1969 8:25 p.m.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>2636</b>			
FULL NAME OF HOSPITAL OR INSTITUTION <b>31</b>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>Baltimore City Hospital 4940 Eastern Avenue Baltimore, Maryland 21224</b>		C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER <b>1209 Gusryan St., Baltimore, Md. 21224</b>			
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2-14-1896</b>	9. AGE (in years lost birthday) <b>73</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Guard</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Pinkerton Detective</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Robert L. Larkins</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>213-1014-48</b>		17. INFORMANT ADDRESS <b>4940 Eastern Avenue BCH Records: Baltimore, Md. 21224</b>	
18. <b>436.0 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>Hypertension &amp; prev. CVA</b>		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>CARDIOPULMONARY ARREST</b> (B) <b>acute and chronic lung infection</b> (C) <b>CVA</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>~</b> <b>6 wks</b> <b>7 wks</b> <b>7 yrs.</b>	
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from <b>December 1</b> 19 <b>69</b> to <b>December 15</b> 19 <b>69</b> that (1) (we) lost saw the deceased alive on <b>December 15</b> 19 <b>69</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Dale N. Schumacher</b>		23B. DATE SIGNED <b>Dec 15, 1969</b>		23C. PHYSICIAN'S NAME (Type) <b>Dale N. Schumacher, M.D.</b>	
23D. ADDRESS <b>Baltimore City Hospital 4940 Eastern Ave., Baltimore, Md. 21224</b>		23E. FUNERAL DIRECTOR <b>Howard H. Hubbard</b>		23F. ADDRESS <b>4107 Wilkens Ave. 21229</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12-19-69</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Lorraine Park Cemetery</b>	
24D. LOCATION <b>Woodlawn, Maryland</b>		24E. DATE REC'D BY HEALTH DEPT. <b>DEC 22 1969</b>		24F. NAME OF REGISTRAR <b>Robert E. [illegible]</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

F-236		69 12557		BALTIMORE CITY HEALTH DEPARTMENT		X		69 12557	
BIRTH NO.		CERTIFICATE OF DEATH				REG. NO.			
1. NAME OF DECEASED (Type or Print)		FOSTER, WILLIAM M Jr.				2. DATE AND HOUR OF DEATH DECEMBER 15, 1969 9:30A M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY				5. CITY OR TOWN			
FULL NAME OF HOSPITAL OR INSTITUTION 40 ST. AGNES HOSPITAL		MARYLAND BALTO 5300				C. CITY OR TOWN BALTIMORE			
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		E. STREET AND NUMBER 211 W MEADOWICK GARTH 21228				D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
5. SEX MALE		6. RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12/16/06		9. AGE (in years last birthday) 62	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) POLICE GUARD		10B. KIND OF BUSINESS OR INDUSTRY BETHLEHEM STEEL		11. BIRTHPLACE (State or foreign country) WASHINGTON D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME WILLIAM FOSTER		14. MOTHER'S MAIDEN NAME MARY (NEE JOHNSTON) FOSTER				17. INFORMANT ADDRESS ST. AGNES HOSPITAL RECORDS			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NONE		16. SOCIAL SECURITY NO. 213-09-3342		17. INFORMANT ADDRESS ST. AGNES HOSPITAL RECORDS					
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Acute Myocardial Infarction</i>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 Min.			
(B) DUE TO, OR AS A CONSEQUENCE OF: <i>Acute Myocardial Infarction</i>		(C) DUE TO, OR AS A CONSEQUENCE OF:				10 days			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		MEDICAL CERTIFICATION							
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)			
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?		22. I certify that (1) (this hospital) attended the deceased from DECEMBER 7 19 69 to DECEMBER 15 19 69 that (2) (we) last saw the deceased alive on DECEMBER 15 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Raymond Bahr</i>		23B. DATE SIGNED 12/15/69		23C. PHYSICIAN'S NAME (Type) RAYMOND BAHR		23D. ADDRESS ST AGNES HOSP. BALTO MD 21229		23E. DATE DEC 22 1969	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE Dec. 18, 1969		24C. NAME OF CEMETERY OR CREMATORY Leview Cem.		24D. LOCATION (City, town, or county) (State) Carroll, Co. Md.		25A. DATE RECEIVED DEC 22 1969	
25B. FUNERAL DIRECTOR G. Truman		25C. ADDRESS Balto. Md. 21229		25D. ADDRESS Schwab 5151 Balto. National Pike		25E. ADDRESS Schwab 5151 Balto. National Pike			

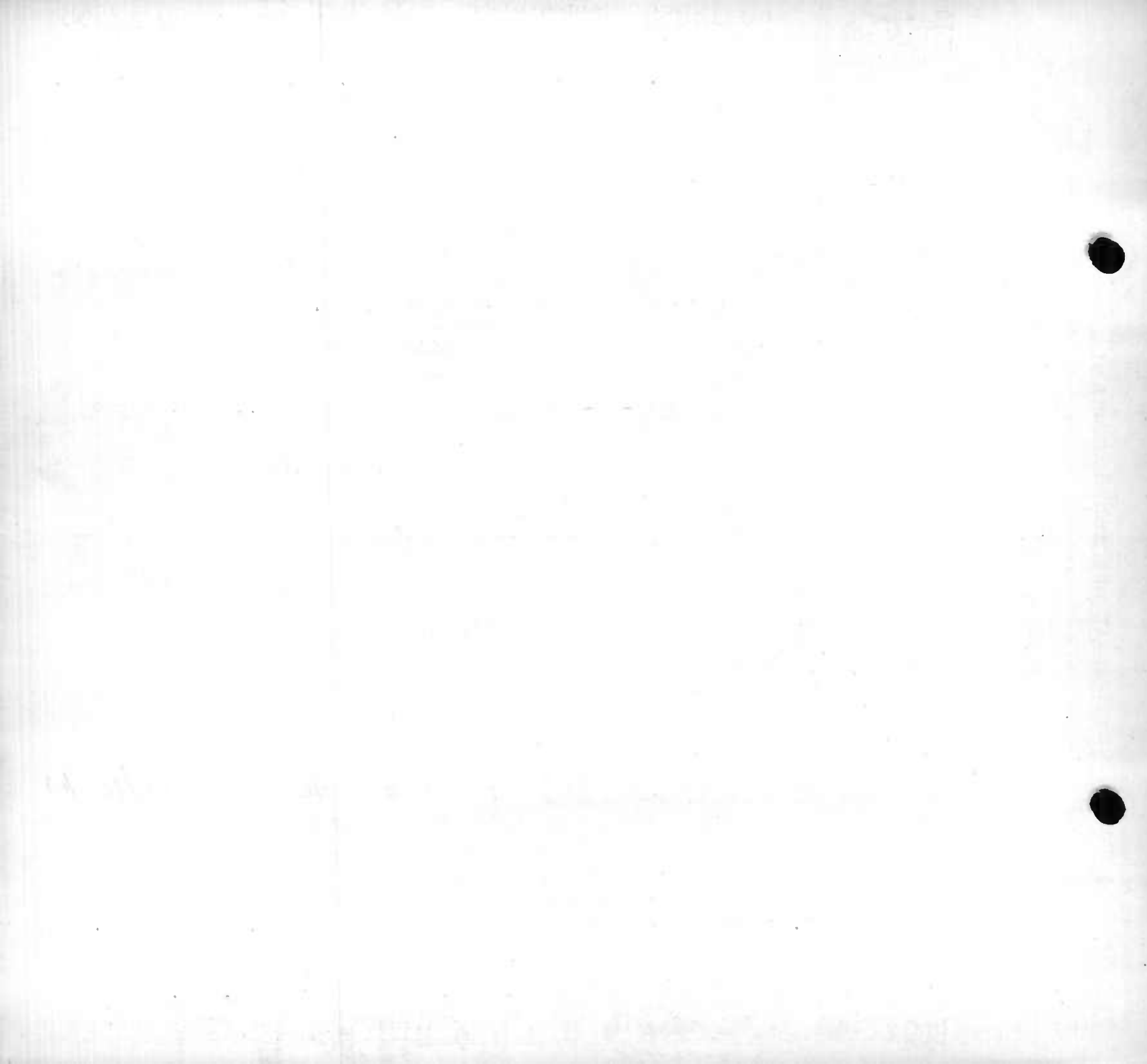




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<div style="display: flex; justify-content: space-between;"> <span>B-260</span> <span>69 12558</span> </div> <div style="display: flex; justify-content: space-between;"> <span>BALTIMORE CITY HEALTH DEPARTMENT</span> <span>CERTIFICATE OF DEATH</span> <span>REG. NO. 69 12558</span> </div>			
1. NAME OF DECEASED (Type or Print) <b>LILLIAN W. BOHAGER</b>		2. DATE AND HOUR OF DEATH <b>Dec. 16, 1969</b> <b>2:30 p. M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>90 House in the Pines (Belvedere)</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md.,</b> B. COUNTY <b>21218</b> C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>1804 Chilton Street</b>	
5. SEX <b>female</b>	6. RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10/25/85</b>
9. AGE (In years last birthday) <b>84</b>		If Under 1 Yr. Months Days    If Under 24 Hrs. Hours Min. 12. CITIZEN OF WHAT COUNTRY?	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Saleslady</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Dalshimer Shoes</b>	
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>William Schoppert</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth Shawan</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>217-22-4718</b>	17. INFORMANT <b>Edward Bohager, Jr., son, above</b>
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Pneumonia</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>Art rel cv duom</b>			
19A. DATE OF OPERATION <b>NO</b>	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>NO</b>	20A. AUTOPSY? (Yes or No) <b>NO</b>	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <b>NO</b>	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>12/16/69</b> to <b>12/16/69</b> and that (I) (we) lost saw the deceased alive on <b>12/16/69</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <b>Maurice Feldman</b>		23B. DATE SIGNED <b>12/17/69</b> Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>	
23C. PHYSICIAN'S NAME (Type) <b>Dr. Maurice Feldman</b>		23D. ADDRESS <b>6610 Cross Country Blvd.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>12/19/69</b>	24C. NAME OF CEMETERY or CREMATORY <b>New Cathedral Cemetery</b>	24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 22 1969</b>	25B. NAME OF REGISTRAR <b>Robert E. Fisher</b>	25C. FUNERAL DIRECTOR <b>Schimunek Funeral Home, Inc.</b>	
		ADDRESS <b>53331 Grehms Lane</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-300		69 12559		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 69 12559	
1. NAME OF DECEASED (Type or Print) <b>JOHN JOSEPH BUTTA</b>				2. DATE AND HOUR OF DEATH <b>Dec. 15, 1969</b> <b>7:30 A</b> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>00 414 S. Exeter St.</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>21202</b>			
				C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <b>414 S. Exeter Street</b>			
5. SEX <b>male</b>	6. RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>3/8/1900</b>	9. AGE (In years lost birthday) <b>69</b>	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Bureau of Transportation - Balto. City</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Baltimore, Md.</b>		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>John Butta</b>				14. MOTHER'S MAIDEN NAME <b>Lucille Ameche</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>YES</b>		16. SOCIAL SECURITY NO. <b>214-20-8118</b>		17. INFORMANT <b>Vincent Butta, 4804 Parkside Dr.</b>			
18. <b>412.2 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>acute cardiac dilatation</b> (B) <b>Coronary heart failure</b> DUE TO, OR AS A CONSEQUENCE OF: (C) <b>Hypertension C.V.D.</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>4h</b> <b>2mo</b> <b>15y</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>12/14</b> <b>1969</b> to <b>12/15</b> <b>1969</b> , that (I) (we) lost saw the deceased alive on <b>12/14</b> <b>1969</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>S. C. Feldman</b>				23B. DATE SIGNED <b>12/17/69</b>			
23C. PHYSICIAN'S NAME (Type) <b>Dr. S. C. Feldman</b>				23D. ADDRESS <b>1440 E. Baltimore St.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12/18/69</b>		24C. NAME of CEMETERY or CREMATORY <b>Holy Redeemer Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 22 1969</b>		25B. NAME OF REGISTRAR <b>John E. Brehms</b>		25C. FUNERAL DIRECTOR <b>Schimunek Funeral Home, Inc.</b>		ADDRESS <b>3381 Brehms Lane</b>	



R-152

69 12560

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 69 12560

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

ANTHONY ROBINSON

2. DATE  
OF DEATHKnown ☐ Estimated ☐

Month

Day

Year

Hour

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL  
OR INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

SOUTH BALTO. GENERAL HOSPITAL (DOA)

3. DATE  
PRONOUNCED DEAD

Month

Day

Year

Hour

December 21, 1969

2:00 A.

M.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

2562

6. SEX

Male

7. RACE

Negro

8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒ NO ☐

9. DATE OF BIRTH

7-22-1950

10. AGE (In years  
lost birthday)

19

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.

E. STREET AND NUMBER

2900 Carver Street Rd

11. BIRTHPLACE (State or foreign country)

BALTO MD

12. CITIZEN OF  
WHAT COUNTRY?

USA

13. FATHER'S NAME

Vernon Robinson

14. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

LABORER

14B. KIND OF BUSINESS OR INDUSTRY

ATLANTIC FURNITURE

15. MOTHER'S MAIDEN NAME

MARIE OWENS

16. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

no

17. SOCIAL  
SECURITY NO.

217-60-1474

18. INFORMANT

Aaris Barnes 2900 Carver Rd

ADDRESS

19.

E965X1

CAUSE OF DEATH

Gunshot wounds (2) of right chest

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART I (A).

20A. DATE OF OPERATION

2

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

yes

22A. EXTERNAL CAUSE WAS  
UNDERLYING ☒ OR CONTRIB-  
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., In or about  
home, form, factory, street, office bldg., etc.)

Street

22C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?

600 Block Cherry Hill Road

22D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY  
(APPROX.) 12-21-69 12:45 A. m.

22E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☒

22F. HOW DID INJURY OCCUR?

Subject, bystander, shot during

Shot during altercation

altercation

23.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐

ACTUAL

SIGNATURE

EXAMINER'S

NAME (Type)

Isidore Mihalakis, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

12/21/69

24A. BURIAL CREMATION,  
REMOVAL (Specify)

Buried

24B. DATE

12/24/69

24C. NAME OF CEMETERY or CREMATORY

Port Arthur

24D. LOCATION (City, town, or county)

Baltimore

(State)

25A. DATE REC'D BY HEALTH DEPT.

DEC 22 1969

25B. NAME OF REGISTRAR

Robert E. Taylor

25C. FUNERAL DIRECTOR

Barbara R. Hays

ADDRESS

6307 J. Edgar

Letter from M.E.'s office 1-21-70 M.H.

1

69 12561

BALTIMORE CITY HEALTH DEPARTMENT

G-650

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 69 12561

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>GREEN NANCE</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour <b>12 17 69 12:15 a.m.</b>	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>48 Maryland General Hospital</b> (If not in hospital or institution, give street address or location)		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>December 17, 1969 12:15 a.m.</b>	
6. SEX <b>Female</b>		7. RACE <b>Negro</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Balto.</b>	
9. DATE OF BIRTH <b>4/29/26</b>		10. AGE (In years last birthday) <b>43</b>	
11. BIRTHPLACE (State or foreign country) <b>Lumberton N C</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Unemployed</b>		15. MOTHER'S MAIDEN NAME <b>Bedie</b>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.	
18. INFORMANT <b>MRs Annabelle Johnson, Same</b>		ADDRESS	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>412.241250.9</b>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Hypertensive cardiovascular disease</b> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>Diabetes mellitus</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION <b>0</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <b>Isidore Mihalakis, M.D.</b> M.D. EXAMINER'S NAME (Type) CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>12/17/69</b>			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <b>12/20/69</b>	
24C. NAME OF CEMETERY or CREMATORY <b>MT Auburn Cemetry</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore Md</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 22 1969</b>		25B. NAME OF REGISTRAR <b>Isidore E. Mihalakis</b>	
25C. FUNERAL DIRECTOR <b>A Halstead</b>		ADDRESS <b>1206 W north Ave</b>	







## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <u>69-23205</u>		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <u>69 12562</u>	
1. NAME OF DECEASED (Type or Print)			2. DATE AND HOUR OF DEATH		
<u>Bely Loy Rogers</u>			<u>12-14-69</u> <u>7 pm</u> M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <u>31</u> <u>Baltimore City Hospitals</u> <u>4940 Eastern Avenue</u> <u>Baltimore, Maryland</u> <u>21224</u>			A. STATE <u>Maryland</u> B. COUNTY <u>2562</u>		
5. SEX <u>Male</u>			C. CITY OR TOWN <u>Baltimore</u>		
6. RACE <u>Negro</u>			D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>			E. STREET AND NUMBER <u>1018 Bethune Road</u> <u>21225</u>		
8. DATE OF BIRTH <u>12-14-1969</u>			9. AGE (In years last birthday) <u>5</u> <u>16</u>		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		
10B. KIND OF BUSINESS OR INDUSTRY			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>James Scott</u>			14. MOTHER'S MAIDEN NAME <u>Sarah Rogers</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		
17. INFORMANT <u>Records: 4940 Eastern Avenue</u> <u>21224</u>			ADDRESS		
18. <u>776.2</u> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (At stating the UNDERLYING CONDITION last.) II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>anoxia, acidosis</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>respiratory distress syndrome</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>immaturity</u>		
19A. DATE OF OPERATION			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		
20A. AUTOPSY? (Yes or No) <u>NO</u>			20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from <u>1:44 pm 12-14 1969</u> to <u>7 pm 12-14 1969</u> that (I) (we) last saw the deceased alive on <u>12-14 1969</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>B.F. Petit</u>			23B. DATE SIGNED <u>12-14-1969</u>		
23C. PHYSICIAN'S NAME (Type) <u>B.F. Petit</u>			23D. ADDRESS <u>Baltimore City Hospitals</u> <u>4940 Eastern Avenue, Baltimore, Maryland 21224</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>12/19/69</u>		24C. NAME OF CEMETERY OR CREMATORY <u>MT Auburn Cemetery</u>	
24D. LOCATION (City, town, or county) <u>Baltimore, Md</u>		24E. DATE REC'D BY HEALTH DEPT. <u>DEC 22 1969</u>		24F. NAME OF REGISTRAR <u>Robert E. Talley</u>	
24G. DATE REC'D BY HEALTH DEPT. <u>DEC 22 1969</u>		24H. NAME OF REGISTRAR <u>Robert E. Talley</u>		24I. FUNERAL DIRECTOR <u>Adolphus Halstead</u> <u>1206 W North Ave</u>	

1944.10.10

1944.10.10

1944.10.10

1944.10.10

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

NELLIE L. PLOWMAN

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

00 2756 The Alameda

6. SEX

Female

7. RACE

White

B. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☒ DIVORCED ☐

9. DATE OF BIRTH

10-17-1891

10. AGE (In years)

lost birthday  
78

If Under 1 Yr. If Under 24 Hrs.

Months Days Hours Min.

11. BIRTHPLACE (State or foreign country)

North Carolina

12. CITIZEN OF

WHAT COUNTRY?  
U.S.A.

2. DATE OF DEATH

Known ☐ Month Day Year Hour  
Estimated ☐ 12 18 69 12:55p M.

3. DATE PRONOUNCED DEAD

Month Day Year Hour  
Dec 18, 1969 12:55pm

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE B. COUNTY

Maryland

907

C. CITY OR TOWN

Balto.

D. INSIDE CITY LIMITS?

YES ☒ NO ☐

E. STREET AND NUMBER

2756 The Alameda

14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Virginia Black

16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

No

17. SOCIAL SECURITY NO.

unknown

18. INFORMANT

ADDRESS

Miller &amp; Kerns Funeral Home Charlotte, N.C.

19.

CAUSE OF DEATH

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

(A) IMMEDIATE CAUSE Arteriosclerotic cardiovascular disease  
DUE TO, OR AS A CONSEQUENCE OF:(B) \_\_\_\_\_  
DUE TO, OR AS A CONSEQUENCE OF:

(C) \_\_\_\_\_

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).

MEDICAL CERTIFICATION

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

No

22A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?

22D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)

22E. INJURY OCCURRED

WHILE AT WORK ☐NOT WHILE AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE EXAMINER'S NAME (Type)

Tsodore Mihalakis, M.D.

CHIEF MEDICAL EXAMINER ☐  
ASSISTANT MEDICAL EXAMINER ☒  
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

12/19/69

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

12-20-1969

24C. NAME OF CEMETERY or CREMATORY

Elmwood Cemetery

24D. LOCATION (City, town, or county) (State)

Charlotte, North Carolina

25A. DATE REC'D BY HEALTH DEPT.

DEC 22 1969

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

Wm. Cook-Brooks Towson 1050 York Rd. 21204

# ACCAIDELMY PRONID

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A-536

69 12564

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

69 12564

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

Mary E. Anderson

2. DATE  
OF  
DEATHKnown ☐  
Estimated ☐

Month

Day

Year

Hour

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL  
OR INSTITUTION(If NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

00

1519 Park Avenue

3. DATE  
PRONOUNCED DEAD

Month

Day

Year

Hour

12

14

69

2:40 P.M.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Md.

B. COUNTY

1401

6. SEX

Female

7. RACE

White

B. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

C. CITY OR TOWN

Balto.

D. INSIDE CITY LIMITS?

YES ☒NO ☐

9. DATE OF BIRTH

May 28, 1896

10. AGE (In years  
last birthday)

53 73

If Under 1 Yr. If Under 24 Hrs.

Months Days Hours Min.

E. STREET AND NUMBER

1515 Park Avenue

11. BIRTHPLACE (State or foreign country)

Carroll County Maryland

12. CITIZEN OF

WHAT COUNTRY?  
U.S.A.

13. FATHER'S NAME

Edward Shamer

14A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Laborer

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Sarah Erb

16. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

17. SOCIAL  
SECURITY NO.

217-01-1915

18. INFORMANT

ADDRESS

Mrs. Justice Denver Manchester, Maryland

19. 412.2 I Hyperten-  
DISEASE OR CONDITION DIRECTLY sive  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

## CAUSE OF DEATH

Arteriosclerotic cardiovascular disease

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

MEDICAL CERTIFICATION

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART I (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

no

22A. EXTERNAL CAUSE WAS  
UNDERLYING ☒ OR CONTRIB-  
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY  
(APPROX.)

22E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinionresulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL

SIGNATURE

EXAMINER'S

NAME (Type)

Russell S. Fisher, M.D.

CHIEF MEDICAL EXAMINER ☒ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

12-15-69

24A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

12/18/69

24C. NAME OF CEMETERY or CREMATORY

Patapsco Cemetery

24D. LOCATION (City, town, or county)

Patapsco Carroll County Md.

25A. DATE REC'D BY HEALTH DEPT.

DEC 22 1969

25B. NAME OF REGISTRAR

Robert E. Fisher, M.D.

25C. FUNERAL DIRECTOR

John E. Goff Funeral Home

ADDRESS

324 N. Main St.  
Hampstead, Md.



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

F-255		69 12565		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 69 12565	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
		ISADORE FISHMAN		12-18-69		13:34 P M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE		B. COUNTY	
42 Sinai HOSPITAL				MARYLAND		2719	
				C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
				BALTIMORE		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER			
				5808 RUBIN AVENUE # 21215			
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH	9. AGE (in years last birthday)	10. Under 1 Yr. Months	11. Under 24 Hrs. Days
MALE	WHITE	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		7-18-18	51		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
CHEF		NER ISRAEL COLLEGE		HUNGARY		USA	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
YEHUDA FISHMAN				NECHA ?			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
NO				MRS. MARGIT FISHMAN, 5808 RUBIN AVENUE #21215			
18. 410.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH			
(This does not mean the mode of dying, e.g., heart failure, oshtenia, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES				Ac. Coronary Occlusion instantaneous			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.				(B) HASCVD 5 yrs.			
				(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from 1965 to present that (I) (we) last saw the deceased alive on Dec. 10 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
David Bakal				12-18-69			
23C. PHYSICIAN'S NAME (Typol)				23D. ADDRESS			
DAVID BAKAL				SINAI HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY		24D. LOCATION (City, town, or county) (State)	
BURIAL		12-19-69		SHOMRA MISHMERES, ROSEDALE		MARYLAND	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS			
DEC 22 1969		J. E. Fisher		SQL LEVINSON & BROS. 6010 REISTERSTOWN RD			

10/10/1912

10/10/1912

10/10/1912

10/10/1912

10/10/1912

10/10/1912

10/10/1912

10/10/1912

10/10/1912

10/10/1912



W-300

69 12566

BALTIMORE CITY HEALTH DEPARTMENT

## CERTIFICATE OF DEATH

REG. NO.

69 12566

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

WHITE, BETTY DOLORES

2. DATE AND HOUR OF DEATH

12/17/69

7:45 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

Baltimore City Hospitals

4940 Eastern Avenue

Baltimore, Maryland 21224

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE

B. COUNTY

Maryland

Baltimore

5300

C. CITY OR TOWN

D. INSIDE CITY LIMITS?

YES ☐NO ☒

E. STREET AND NUMBER

454 Barrison Point Road 21221

5. SEX

Female

6. RACE

White

7. MARRIED ☐NEVER MARRIED ☐WIDOWED ☒DIVORCED ☐

8. DATE OF BIRTH

7-18-1915

9. AGE (in years  
last birthday)

54

If Under 1 Yr. If Under 24 Hrs.

Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

-

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Andrew ~~Plum~~ Plum

14. MOTHER'S MAIDEN NAME

~~Thelma~~ Tina Pencek15. Was Deceased Ever in U. S. Armed Forces?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

None

17. INFORMANT

ADDRESS

Records: BCH-4940 Eastern Avenue 21224

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving  
rise to the above cause (A) stating the  
UNDERLYING CONDITION last.(A) IMMEDIATE CAUSE CARDIORESPIRATORY ARREST  
DUE TO, OR AS A CONSEQUENCE OF:(B) PULMONARY EMBOLISM? ATRIAL FIB.  
DUE TO, OR AS A CONSEQUENCE OF:

(C)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART 1 (A).

THROMBOSIS OF MESENTERIC ARTERY

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMEDSMALL BOWEL  
INFARCTION

20A. AUTOPSY? (Yes or No)

YES 12/19/69

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

YES

21A. ACCIDENT WAS UNDERLYING  
OR CONTRIBUTING CAUSE OF  
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg,  
etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At  
Work ☐Not While  
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 11/26/69 19 to 12/17/69 19  
that (I) (we) last saw the deceased alive on 12/17/69 19 and that in (my) (our) opinion death occurred on the date  
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Juan De Dios Lora

DEGREE

Attending  
Phys. ☐Med.  
Director ☐Staff  
Phys. ☒

23B. DATE SIGNED

12-17-1969

23C. PHYSICIAN'S  
NAME (Type)

Juan De Dios Lora

DEGREE

23D. ADDRESS

Baltimore City Hospitals  
6154 EAST PRATT ST., BALTIMORE, M D24A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

12/22/69

24C. NAME of CEMETERY or CREMATORY

St. Stanislaus

24D. LOCATION

(City, town, or county)

(State)

Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.

DEC 22 1969

25B. NAME OF REGISTRAR

Robert E. Taylor, MD

25C. FUNERAL DIRECTOR

M. B. SADOWSKI &amp; SONS, 1808 EASTERN AVE

ADDRESS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

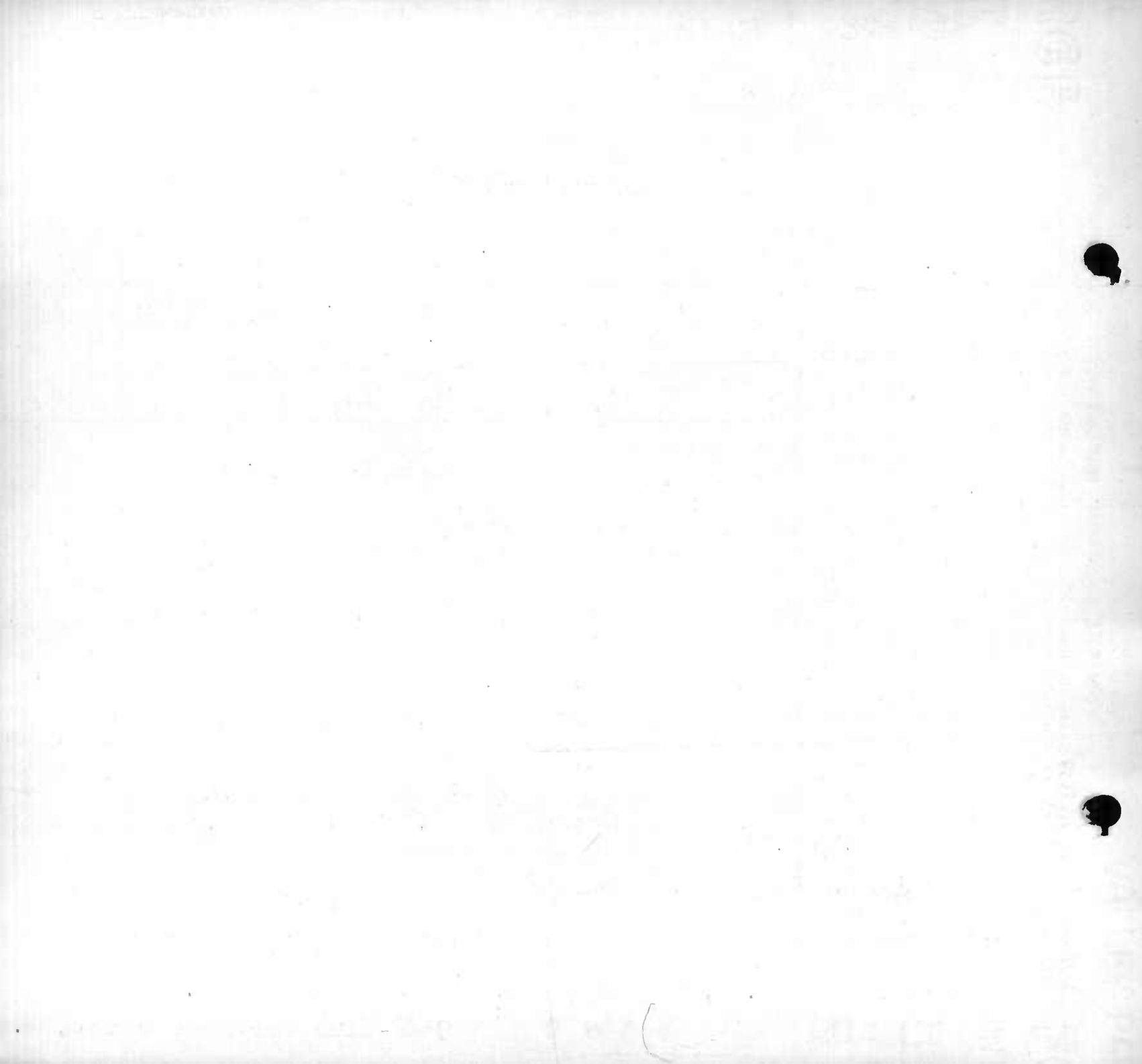
A-400		69 12567		BALTIMORE CITY HEALTH DEPARTMENT		69 12567	
BIRTH NO.				REG. NO.			
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
Aull Frederick J.				12/18/1969 2:50 PM.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE B. COUNTY			
3544				Maryland 2610			
5. SEX M				6. RACE W			
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH 5/4/98			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				9. AGE (in years last birthday) 71			
Retired Railway Exp.				10B. KIND OF BUSINESS OR INDUSTRY Retired Railway Exp.			
11. BIRTHPLACE (State or foreign country)				12. CITIZEN OF WHAT COUNTRY?			
MD.				USA.			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
John Clinton Aull				Elizabeth Paruch			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or doles of service)				16. SOCIAL SECURITY NO.			
No				714 105740			
17. INFORMANT				ADDRESS			
Mrs. Helen M. Aull				405 N. Clinton St.			
18. 199.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)				CAUSE OF DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Fertile Terminal Ca.			
				(B) metastatic Carcinoma DUE TO, OR AS A CONSEQUENCE OF:			
				(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			
0							
20A. AUTOPSY? (Yes or No)				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
No							
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)							
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED			
				While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
21F. HOW DID INJURY OCCUR?							
22. I certify that (I) (this hospital) attended the deceased from 12/12/69 19 to 12/18/1969 19 that (I) (we) last saw the deceased alive on 12/18/69 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
J. J. J.							
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
F. J. J.							
24A. BURIAL CREMATION, REMOVAL (Specify)				24B. DATE			
Burial				12/22/69			
24C. NAME OF CEMETERY or CREMATORY				24D. LOCATION (City, town, or county) (State)			
Sacred Heart of Jesus Cemetery, Baltimore, Maryland							
25A. DATE REC'D BY HEALTH DEPT.				25B. NAME OF REGISTRAR			
DEC 22 1969				Robert E. J. J.			
25C. FUNERAL DIRECTOR				ADDRESS			
John A. J. J.				3000 E. Baltimore St.			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

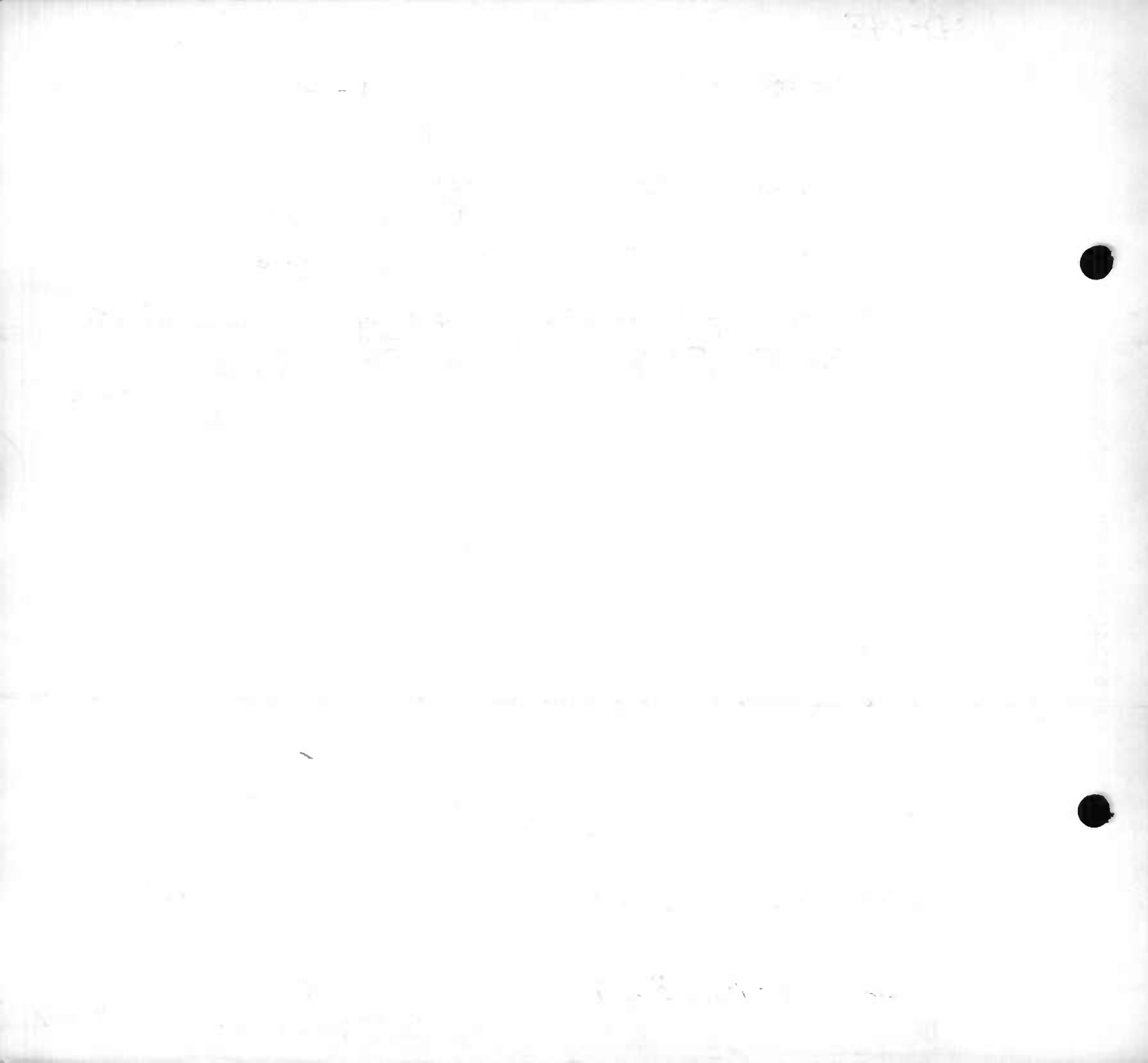
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <b>69 12568</b>	
S-420		69 12568		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <b>PAUL A. SHILKE</b>		2. DATE AND HOUR OF DEATH <b>12-19-69 6:20 A.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b> C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
FULL NAME OF HOSPITAL OR INSTITUTION <b>North Charles Gen. Hospital</b>		E. STREET AND NUMBER <b>19 Harrison Blvd, 21220</b>			
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4-20-1890</b>	9. AGE (In years last birthday) <b>79</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Maintenance Man</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Nursing Home</b>		11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		13. FATHER'S NAME <b>OTTO SHILKE</b>			
14. MOTHER'S MAIDEN NAME <b>Sara Garman</b>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or Unknown) (If yes, give war or dates of service) <b>WW 1</b>			
16. SOCIAL SECURITY NO. <b>183-18-8604</b>		17. INFORMANT <b>Mrs. Mary Klein - 6321 Pearce St.</b>			
18. <b>441.2 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Acute &amp; Chronic Heart Failure</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Heart Failure</b> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <b>11-14-69</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Abdominal Aneurysm</b>		20A. AUTOPSY? (Yes or No) <b>NO</b>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		(If in Baltimore City, give exact location)			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>Oct 30 19 69</b> to <b>Dec 19 19 69</b> , that (I) (we) last saw the deceased alive on <b>Dec. 19 19 69</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Mariquita Cassino-Lin MD</b>				23B. DATE SIGNED <b>12-19-69</b>	
23C. PHYSICIAN'S NAME (Type) <b>MARIQUITA CASSINO-LIN MD</b>				23D. ADDRESS <b>North Charles Gen. Hospital</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>Dec. 21, 1969</b>		24C. NAME OF CEMETERY or CREMATORY <b>Stiltz Cemetery</b>	
24D. LOCATION (City, town, or county) (State) <b>Glen Rock, Pa.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>DEC 22 1969</b>			
25B. NAME OF REGISTRAR <b>John E. Kelly</b>		25C. FUNERAL DIRECTOR <b>Tipton - Eline Funeral Home</b>			
25D. ADDRESS <b>Hampstead, Md.</b>					



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				X		REG. NO.	
B-645 69 12569				69 12569			
BIRTH NO.				2. DATE AND HOUR OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>Dorothy A. BERLIN</u>				12-12-69 11:50 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>40 ST. AGNES HOSPITAL</u>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE <u>MARYLAND</u>		B. COUNTY <u>Balto. Co.</u>	
				C. CITY OR TOWN <u>BALTIMORE</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <u>189 COLCHESTER ROAD</u>			
5. SEX <u>FEMALE</u>	6. RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-10-1916</u>	9. AGE (In years last birthday) <u>53</u>	If Under 1 Yr. Months: Days: Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>		11. BIRTHPLACE (State or foreign country) <u>PENNA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>WALTER C. Ekin</u>				14. MOTHER'S MAIDEN NAME <u>MATTIE FRYE</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>216-05-0904</u>		17. INFORMANT <u>T. Clark Berlin</u>			
				ADDRESS <u>189 OAKLEE VILLAGE BALTO 21229, Md.</u>			
18. <u>410.9 I</u> CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Myocardial Infarction</u>				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Coronary Arteriosclerosis</u>				(B) DUE TO, OR AS A CONSEQUENCE OF:			
				(C) _____			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>Feb 1966</u> to <u>Dec 12 1969</u> that (I) (we) last saw the deceased alive on <u>Dec 7 1969</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>[Signature]</u>				23B. DATE SIGNED <u>12/12/69</u>		23C. PHYSICIAN'S NAME (Type) <u>[Signature]</u>	
23D. ADDRESS <u>[Signature]</u>				23E. ADDRESS <u>[Signature]</u>			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
<u>BURIAL</u>		<u>12-17-69</u>		<u>BALTO. NATIONAL</u>		<u>BALTO, Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>DEC 22 1969</u>		25B. NAME OF REGISTRAR <u>[Signature]</u>		25C. FUNERAL DIRECTOR <u>[Signature]</u>		ADDRESS <u>[Signature]</u>	





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

W-200 69 12570				BALTIMORE CITY HEALTH DEPARTMENT		69 12570	
BIRTH NO.				REG. NO.			
1. NAME OF DECEASED (Type or Print) <b>Martin E. Wascoe (Wasko)</b>				2. DATE AND HOUR OF DEATH <b>Dec. 16, 1969</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <b>Sinai Hospital</b> <b>42</b>				A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b>			
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
				E. STREET AND NUMBER <b>6115 Collinsway Rd., Baltimore, Md. 21228</b>			
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>1910</b> <b>August 15, 1910</b>		9. AGE (In years lost birthday) <b>59</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>School Counselor</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Dept. of Education</b>		11. BIRTHPLACE (State or foreign country) <b>Shamokin, Pa.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Martin Wascoe</b>				14. MOTHER'S MAIDEN NAME <b>Catherine Andrzejewska</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>yes 1918</b>		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <b>Mrs. Florence N. Wascoe, 6116 Collinsway Rd.</b>			
18. <b>410.0 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b>				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Myocardial infarction</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>8 hours</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) <b>Hypertensive CVD</b> DUE TO, OR AS A CONSEQUENCE OF:		<b>10 years</b>	
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <input type="checkbox"/>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>March 31, 1952</b> to <b>Dec 16, 1969</b> , that (I) (we) last saw the deceased alive on <b>Nov 16, 1969</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Reinard Gaffey M.D.</b>				Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <b>12/18/69</b>	
23C. PHYSICIAN'S NAME (Type) <b>Reinard Gaffey M.D.</b>				23D. ADDRESS <b>6115 Collinsway Rd., Baltimore, Md. 21228</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Cremation</b>		24B. DATE <b>Dec. 19, 1969</b>		24C. NAME OF CEMETERY or CREMATORY <b>Loudon Park Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 22 1969</b>		25B. NAME OF REGISTRAR <b>Robert E. Fisher, R.D.</b>		25C. FUNERAL DIRECTOR <b>G. Truman Schwab</b>		ADDRESS <b>5151 Balto. Natl. Pike, Baltimore, Maryland, 21229</b>	

Thyroid information

Hypothyroidism

March 10 1984

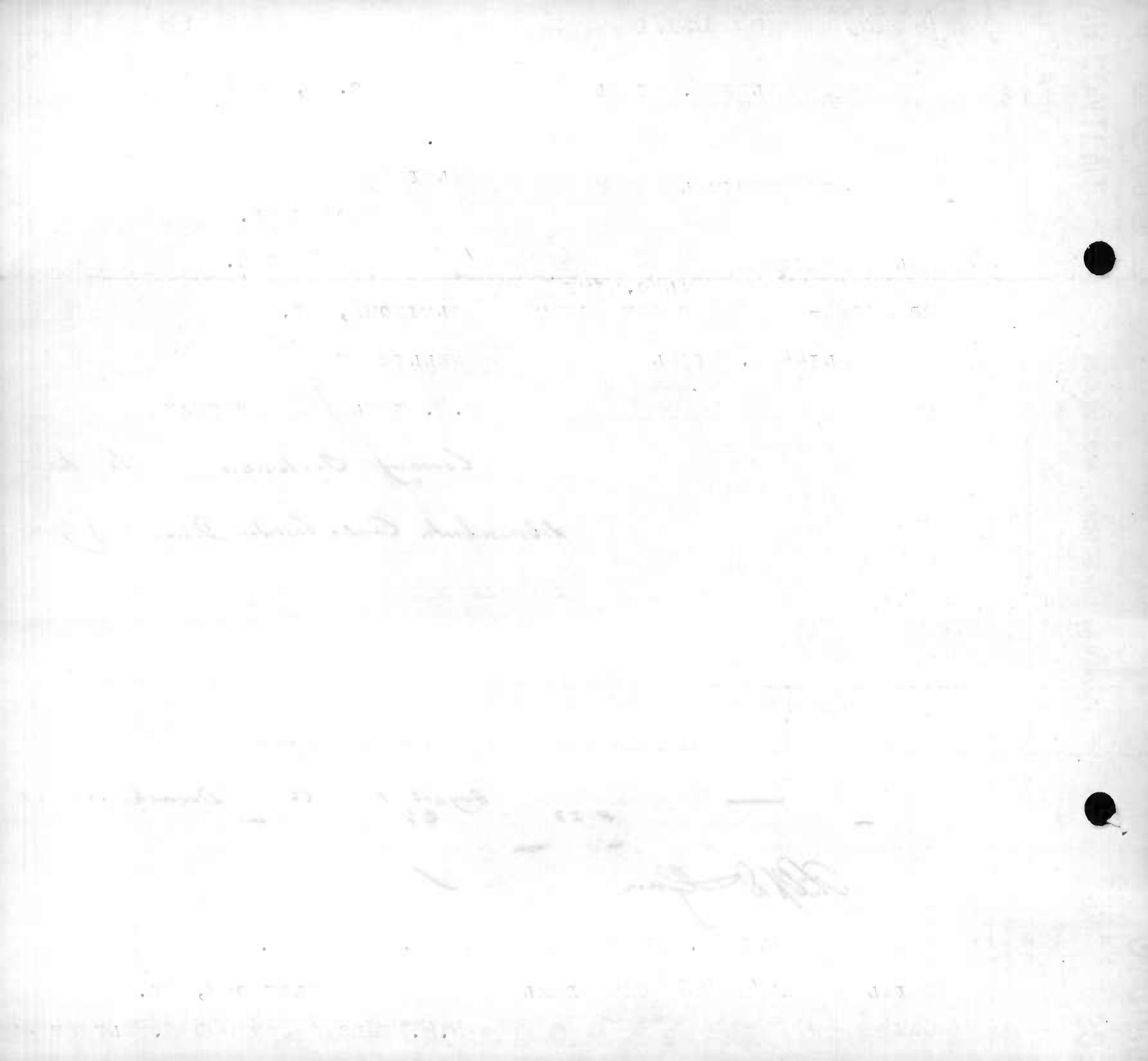
Thyroid and Hypo

1/10/84

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

D-400		69 12571		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		REG. NO. 69 12571	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
		JULES F. DIEHL				DEC. 15, 1969			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)				M.			
FULL NAME OF HOSPITAL OR INSTITUTION		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				C. CITY OR TOWN			
37 MERCY HOSPITAL						D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			
						E. STREET AND NUMBER			
						5804 EDGE PARK RD.			
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years lost birthday)	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
MALE	WHITE	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9/6/06	63 YRS.					
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?			
APPRAISER-		ORPHANS COURT		BALTIMORE, MD.					
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME							
JULIUS F. DIEHL		NELLIE DYER							
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS					
				WM. M. DIEHL 6216 MOSSWAY					
18. 410.9 I		CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		(A) IMMEDIATE CAUSE				1/2 hour			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		Coronary Occlusion							
ANTECEDENT CAUSES		(B) Arteriosclerotic Cardio-Vascular Disease				3 years			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.		DUE TO, OR AS A CONSEQUENCE OF:							
II		(C) _____							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).									
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?					
(Month) (Day) (Year) (Hour)		While At <input type="checkbox"/> Not While <input type="checkbox"/> Work At Work							
22. I certify that (I) (this hospital) attended the deceased from August 1 1966 to December 15 1968, that (I) (we) last saw the deceased alive on 8-27 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE		23B. DATE SIGNED							
PHILIP D. FLYNN		12/16/69							
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS							
PHILIP D. FLYNN		11 E. CHASE ST.							
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)			
BURIAL		12/19/69		CATHEDRAL		BALTIMORE, MD.			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS					
DEC 22 1969		Robert E. Taylor, M.D.		H. W. MEARS & SON 805 N. CALVERT ST					



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <b>69 12572</b>	
<b>J-520</b>		<b>69 12572</b>		<b>CERTIFICATE OF DEATH</b>	
1. NAME OF DECEASED (Type or Print) <b>John A. Jones</b>		2. DATE AND HOUR OF DEATH <b>Dec. 17, 1969</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  <b>00 3620 W. Belvedere Ave. 21215</b>		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>2788</b> C. CITY OR TOWN <b>Balto; 21215</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>3620 W. Belvedere Ave.</b>			
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 4, 1891</b>		9. AGE (In years last birthday) <b>78 yrs</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>retire foreman</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>USA P. O.</b>		11. BIRTHPLACE (State or foreign country) <b>Balto</b>	
13. FATHER'S NAME <b>Artur H. Jones</b>		14. MOTHER'S MAIDEN NAME <b>Anna M. Bowers</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>212 01 5693</b>		17. INFORMANT <b>21215</b> <b>Anna M. Hyzy, 3620 W. Belvedere Ave.,</b>	
18. <b>250.9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Myocardial arrest</b> <b>Diabetes</b> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>8-69</b> to <b>Dec 17 1969</b> , that (I) (we) last saw the deceased alive on <b>Dec 5 1969</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Vicente M. Rivas</b>				23B. DATE SIGNED <b>12-18-69</b>	
23C. PHYSICIAN'S NAME (Type) <b>Vicente M. Rivas</b>				23D. ADDRESS <b>1632 Reisterstown Rd. Pikesville, Md.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>burial</b>		24B. DATE <b>Dec. 20, 1969</b>		24C. NAME OF CEMETERY or CREMATORY <b>Pipe Creek Cem.</b>	
		24D. LOCATION <b>Garroll Co; Md.</b>		24E. ADDRESS <b>8728 Liberty Rd. 21133</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 22 1969</b>		25B. NAME OF REGISTRAR <b>Loring Byers</b>		25C. FUNERAL DIRECTOR <b>Loring Byers</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<div style="display: flex; justify-content: space-between;"> <span>69 12573</span> <span>BALTIMORE CITY HEALTH DEPARTMENT</span> <span>69 12573</span> </div> <h2 style="text-align: center;">CERTIFICATE OF DEATH</h2>			
BIRTH NO. <span style="font-size: 1.5em;">B-425</span> 1. NAME OF DECEASED (Type or Print) <span style="font-size: 1.2em;">BELSINGER, ALMA C</span>		2. DATE AND HOUR OF DEATH <div style="display: flex; justify-content: space-between;"> <span>DECEMBER 19, 1969</span> <span>10:15A M.</span> </div>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <div style="display: flex; justify-content: space-between;"> <div>                     FULL NAME OF HOSPITAL OR INSTITUTION  <span style="font-size: 1.5em;">40</span> ST. AGNES HOSPITAL                 </div> <div>                     (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)                 </div> </div>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) <div style="display: flex; justify-content: space-between;"> <div>                     A. STATE  <span style="font-size: 1.2em;">MARYLAND</span> </div> <div>                     B. COUNTY  <span style="font-size: 1.2em;">BALTIMORE</span> </div> </div>	
5. SEX <span style="font-size: 1.2em;">FEMALE</span>		6. RACE <span style="font-size: 1.2em;">WHITE</span>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <span style="font-size: 1.2em;">01/07/01</span>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">NONE</span>		9. AGE (in years last birthday) <span style="font-size: 1.2em;">68</span>	
10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <span style="font-size: 1.2em;">MARYLAND</span>	
13. FATHER'S NAME <span style="font-size: 1.2em;">HENRY CONTNER (Kontner)</span>		12. CITIZEN OF WHAT COUNTRY? <span style="font-size: 1.2em;">U.S.A.</span>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <span style="font-size: 1.2em;">NONE</span>		14. MOTHER'S MAIDEN NAME <span style="font-size: 1.2em;">MARY (NEE FLESTER) CONTNER (Kontner)</span>	
16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <span style="font-size: 1.2em;">ST. AGNES HOSPITAL RECORDS</span>	
18. CAUSE OF DEATH <div style="display: flex; justify-content: space-between;"> <div>                     DISEASE OR CONDITION DIRECTLY LEADING TO DEATH                      (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)                      ANTECEDENT CAUSES                      DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.                 </div> <div>                     (A) IMMEDIATE CAUSE  <span style="font-size: 1.2em;">acute Myocardial infarction</span>                      DUE TO, OR AS A CONSEQUENCE OF:                 </div> <div>                     (B) <span style="font-size: 1.2em;">Ventricular fibrillation</span>                      DUE TO, OR AS A CONSEQUENCE OF:                 </div> <div>                     (C)                 </div> </div>			
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION <span style="font-size: 1.2em;">2</span>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) <span style="font-size: 1.2em;">YES</span>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <span style="font-size: 1.2em;">DECEMBER 18</span> 19 <span style="font-size: 1.2em;">69</span> to <span style="font-size: 1.2em;">DECEMBER 19</span> 19 <span style="font-size: 1.2em;">69</span> that (I) (we) last saw the deceased alive on <span style="font-size: 1.2em;">DECEMBER 19</span> 19 <span style="font-size: 1.2em;">69</span> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <span style="font-size: 1.5em;">H. Shams, M.D.</span>		23B. DATE SIGNED <span style="font-size: 1.2em;">12-19-69</span>	
23C. PHYSICIAN'S NAME (Type) <span style="font-size: 1.2em;">ABDOLLAH SHAMS, BIRZADEH MD</span>		23D. ADDRESS <span style="font-size: 1.2em;">BALTIMORE, MD 21229 ST AGNES HOSP: CATON &amp; WILKENS AVES.</span>	
24A. BURIAL CREMATION, REMOVAL (Specify) <span style="font-size: 1.2em;">Cremation</span>		24B. DATE <span style="font-size: 1.2em;">12/22/69</span>	
24C. NAME OF CEMETERY OR CREMATORY <span style="font-size: 1.2em;">Loudon Park Cemetery</span>		24D. LOCATION (City, town, or county) (State) <span style="font-size: 1.2em;">Baltimore Maryland</span>	
25A. DATE REC'D BY HEALTH DEPT. <span style="font-size: 1.5em;">DEC 22 1969</span>		25B. NAME OF REGISTRAR <span style="font-size: 1.2em;">Robert E. Taylor</span>	
25C. FUNERAL DIRECTOR <span style="font-size: 1.2em;">Witzke Funeral Home</span>		ADDRESS <span style="font-size: 1.2em;">4101 Edmondson Ave.</span>	

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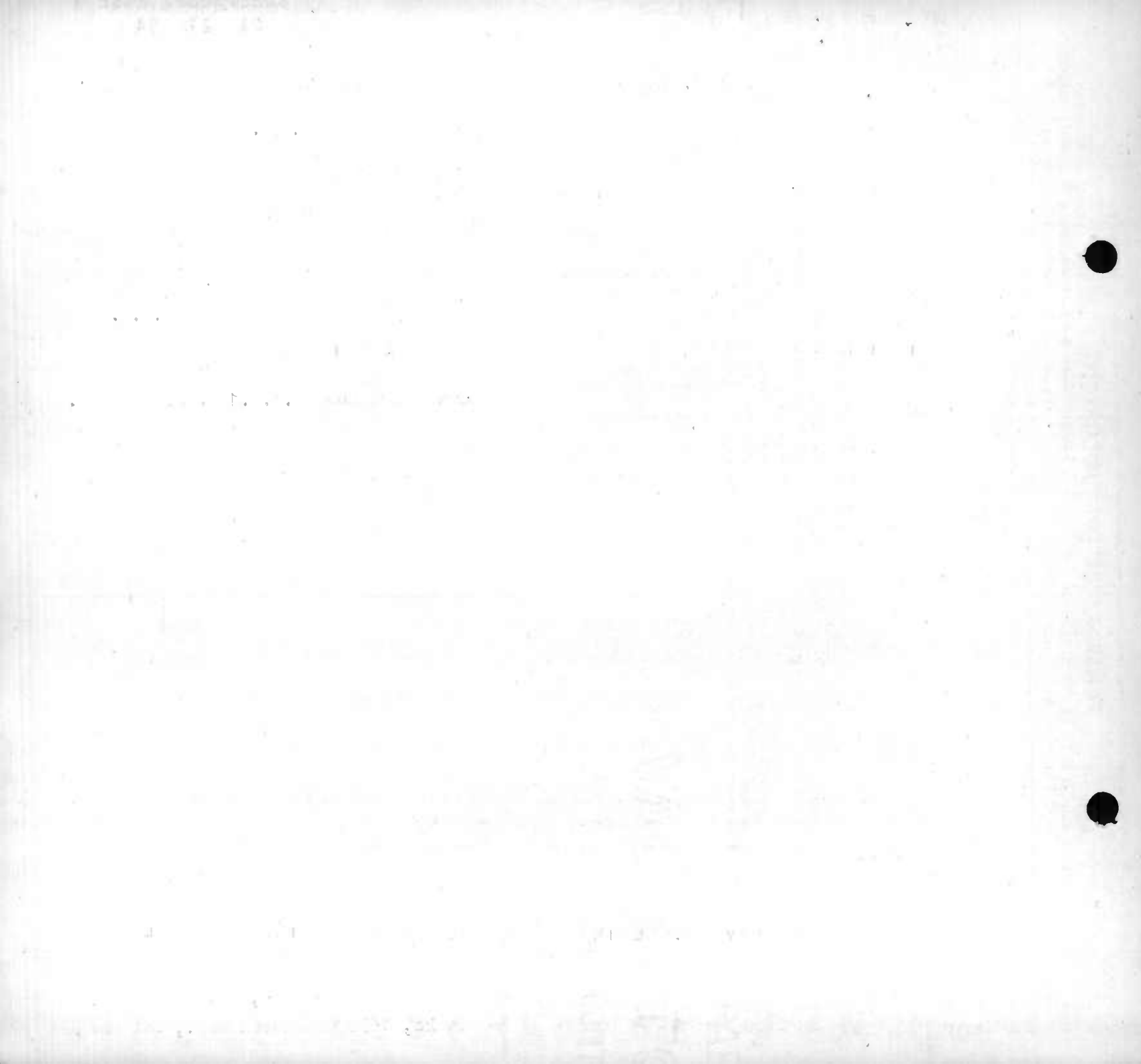
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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

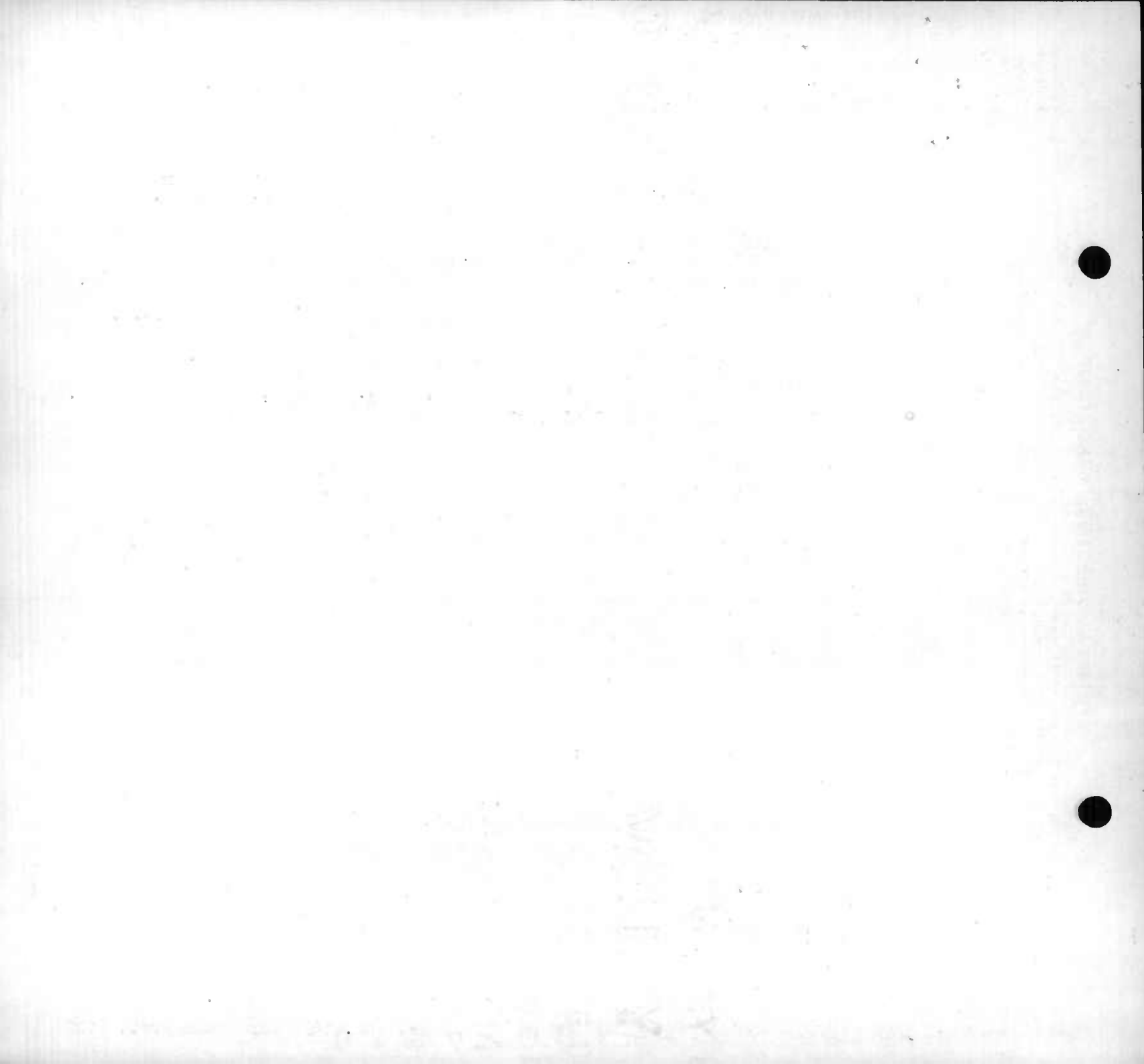
Baltimore City Health Department				REG. NO. 27 94	
B-351 69 12574		69 12574			
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
ROSE H. BADENHOOP		12-19-69		5:05 P M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE B. COUNTY			
33 THE JOHNS HOPKINS HOSPITAL		MARYLAND A. A. CO 5200			
		C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
		PASADENA		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
		E. STREET AND NUMBER			
		R F D 1 Box 15A			
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
FEMALE	WHITE	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	1 27 94	75	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
House wife				Maryland	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
WILLIAM HOFMEISTER		LENA REINHOLD		U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
no				Herman Badenhop R.F.D.1 Pasadena MD.	
18. 207.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH			
ANTECEDENT CAUSES		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: INTRACEREBRAL Hemorrhage			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) Chronic leukemia DUE TO, OR AS A CONSEQUENCE OF:			
		(C).....			
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
O				NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 12/19 19 69 to 12/19 19 69, that (I) (we) lost saw the deceased alive on 12/19, 5:05 pm 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Harvey G. Klein				12/19/69	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
HARVEY G. KLEIN		THE JOHNS HOPKINS HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		12/22/69		Woodlawn Cemetery	
		24D. LOCATION		24E. (City, town, or county) (State)	
		Baltimore, Md			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
DEC 22 1969		Robert E. Taylor		Widzler, 1630 Edmondson Ave., Catonsville	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

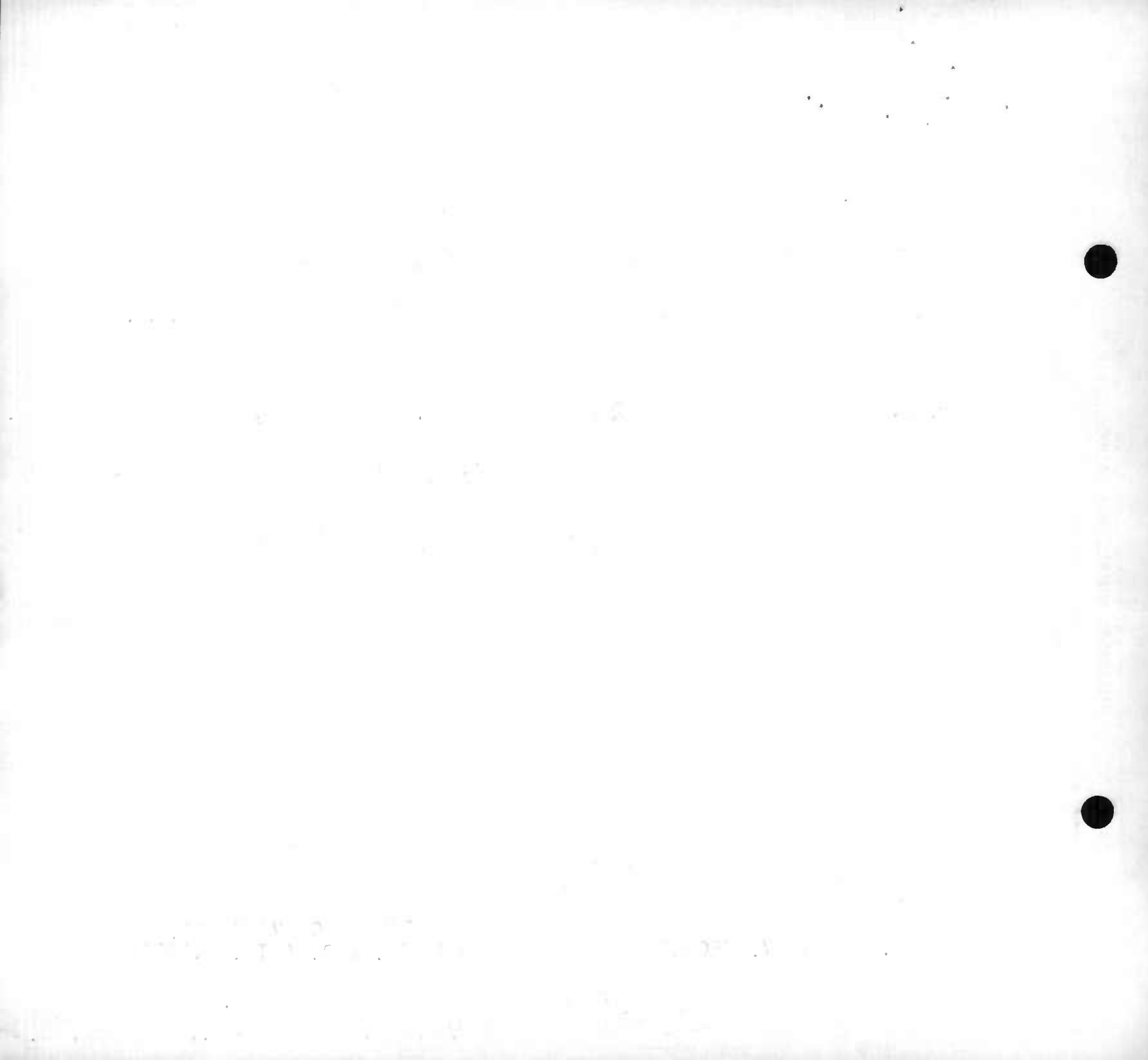
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="float: right;">69 12575</span>	
<div style="display: flex; justify-content: space-between;"> <span style="font-size: 1.5em;">B-623</span> <span>69 12575</span> </div> <div style="text-align: center; font-weight: bold; font-size: 1.2em;">CERTIFICATE OF DEATH</div>					
<div style="display: flex; justify-content: space-between;"> <div> <b>BIRTH NO.</b>            1. NAME OF DECEASED (Type or Print) <span style="font-size: 1.2em;">ANTHONY BROCATO</span> </div> <div> <b>2. DATE AND HOUR OF DEATH</b>  <span style="font-size: 1.2em;">10:20 am 12/19/69</span> </div> </div>					
<b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b>  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <span style="font-size: 1.2em;">Lutheran Hospital</span> <span style="font-size: 1.5em;">46 Lutheran Hospital</span>			<b>4. USUAL RESIDENCE</b> (Where deceased lived, if institution; residence before admission) A. STATE <span style="font-size: 1.2em;">Maryland</span> B. COUNTY <span style="font-size: 1.2em;">2037</span> C. CITY OR TOWN <span style="font-size: 1.2em;">Baltimore</span> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <span style="font-size: 1.2em;">407 Lyndhurst St.</span> <span style="font-size: 1.2em;">407, Lyndhurst Ave.</span>		
<b>5. SEX</b> <span style="font-size: 1.2em;">MM</span>	<b>6. RACE</b> <span style="font-size: 1.2em;">White</span> <span style="font-size: 1.2em;">white</span>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <span style="font-size: 1.2em;">4/17/1886</span>	<b>9. AGE</b> (In years lost birthday) <span style="font-size: 1.2em;">83</span>	<b>If Under 1 Yr.</b> Months Days <b>If Under 24 Hrs.</b> Hours Min. 
<b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">Retired</span>			<b>10B. KIND OF BUSINESS OR INDUSTRY</b> 		<b>11. BIRTHPLACE</b> (State or foreign country) <span style="font-size: 1.2em;">Ireland</span>
<b>12. CITIZEN OF WHAT COUNTRY?</b> <span style="font-size: 1.2em;">U.S.A.</span>			<b>13. FATHER'S NAME</b> <span style="font-size: 1.2em;">Brocato</span>		
<b>14. MOTHER'S MAIDEN NAME</b> <span style="font-size: 1.2em;">Mary</span>			<b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service) <span style="font-size: 1.2em;">no</span>		
<b>16. SOCIAL SECURITY NO.</b> <span style="font-size: 1.2em;">218-58-9494-J</span>			<b>17. INFORMANT</b> <span style="font-size: 1.2em;">Mrs. Brocato</span> ADDRESS <span style="font-size: 1.2em;">407 Lyndhurst St.</span> <span style="font-size: 1.2em;">Francis Brocato (wife)</span> <span style="font-size: 1.2em;">Same</span>		
<b>18. CAUSE OF DEATH</b> <div style="display: flex;"> <div style="flex: 1;"> <b>I</b>  <b>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b>            (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)   <b>ANTECEDENT CAUSES</b>            DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.   <b>II</b>            OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).         </div> <div style="flex: 1;"> <b>(A) IMMEDIATE CAUSE</b>            DUE TO, OR AS A CONSEQUENCE OF:  <span style="font-size: 1.5em;">Severe dehydration</span>   <b>(B)</b>            DUE TO, OR AS A CONSEQUENCE OF:  <span style="font-size: 1.5em;">? Metastatic Ca.</span>   <b>(C)</b> </div> </div>					
<b>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</b> 					
<b>19A. DATE OF OPERATION</b> <span style="font-size: 1.2em;">0</span>		<b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b> 		<b>20A. AUTOPSY?</b> (Yes or No) <span style="font-size: 1.2em;">No</span>	
<b>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</b> 		<b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner) <input type="checkbox"/>			
<b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		<b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)			
<b>21D. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (APPROX.)		<b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		<b>21F. HOW DID INJURY OCCUR?</b>	
<b>22. I certify that (I) (this hospital) attended the deceased from</b> <span style="font-size: 1.2em;">12/18/69</span> <b>19</b> <b>to</b> <span style="font-size: 1.2em;">12/19</span> <b>19</b> <b>that (I) (we) lost saw the deceased alive on</b> <span style="font-size: 1.2em;">10:20 am 12/19</span> <b>19</b> <b>69</b> <b>and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.</b>					
<b>23A. SIGNATURE</b> <span style="font-size: 1.5em;">Phastel</span>				<b>23B. DATE SIGNED</b> 	
<b>23C. PHYSICIAN'S NAME</b> (Type) <span style="font-size: 1.2em;">PRATIMA KHASTAGIE</span>				<b>23D. ADDRESS</b> <span style="font-size: 1.2em;">Lutheran Hospital</span>	
<b>24A. BURIAL CREMATION, REMOVAL</b> (Specify) <span style="font-size: 1.2em;">Burial</span>		<b>24B. DATE</b> <span style="font-size: 1.2em;">12/22/69</span>		<b>24C. NAME OF CEMETERY or CREMATORY</b> <span style="font-size: 1.2em;">New Cathedral Cemetery</span>	
<b>24D. LOCATION</b> (City, town, or county) (State) <span style="font-size: 1.2em;">Baltimore, Md.</span>		<b>25A. DATE REC'D BY HEALTH DEPT.</b> <span style="font-size: 1.2em;">DEC 22 1969</span>			
<b>25B. NAME OF REGISTRAR</b> <span style="font-size: 1.2em;">Robert E. Sallay</span>		<b>25C. FUNERAL DIRECTOR</b> <span style="font-size: 1.2em;">Witzke, Inc.</span> ADDRESS <span style="font-size: 1.2em;">1630 Edmondson Ave., 21228</span>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

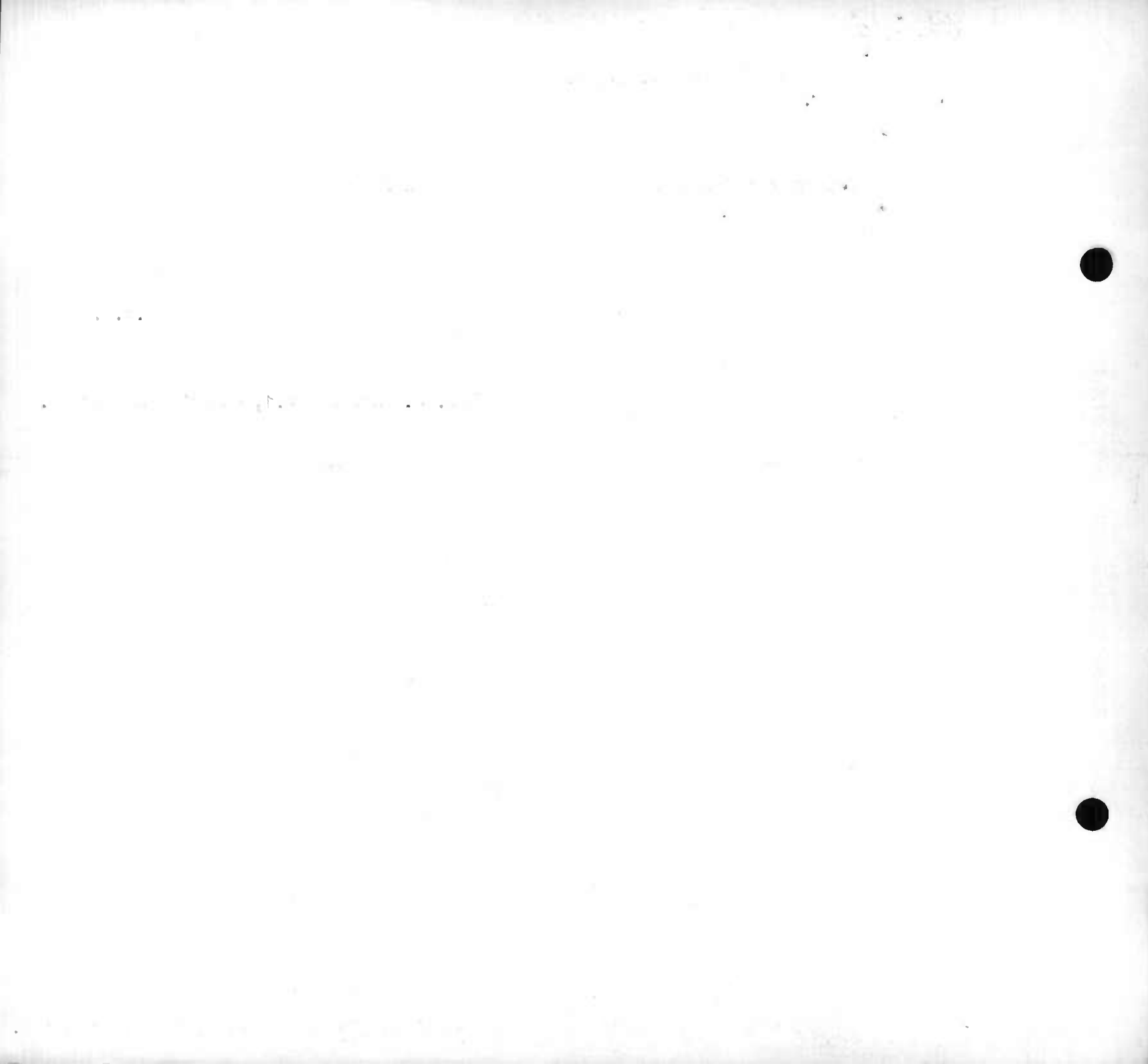
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 69 12576	
5452 69 12576 SCHEILING CERTIFICATE OF DEATH					
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Oscar G Scheiling</i>		2. DATE AND HOUR OF DEATH <i>12/18/69 9:30 AM</i>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <i>Union Memorial Hospital</i>			A. STATE <i>Md</i> B. COUNTY <i>906</i>		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			C. CITY OR TOWN <i>Baltimore</i>		D. INSIDE CITY LIMITS YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
E. STREET AND NUMBER <i>2926 Harbor Rd</i>					
5. SEX <i>M</i>	6. RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>8/28</i>	9. AGE (In years last birthday) <i>41</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Cigar Maker</i>		11. BIRTHPLACE (State or foreign country) <i>Md</i>	
13. FATHER'S NAME <i>?</i>		14. MOTHER'S MAIDEN NAME <i>?</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>unknown</i>		16. SOCIAL SECURITY NO. <i>217 35 2041</i>		17. INFORMANT <i>Mr. August Kutlik, 4431 Old Frederick Rd.</i>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>423X1 Bilateral Pleural Effusion</i>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>mm</i>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Hemo-Pericardium</i>		
			(B) DUE TO, OR AS A CONSEQUENCE OF:		
			(C) _____		
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <i>12/15/69</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>YES</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>12/15/69</i> to <i>12/18/69</i> that (I) (we) last saw the deceased alive on <i>12/18/69</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Ronald V. Geckler</i>				23B. DATE SIGNED <i>12/18/69</i>	
23C. PHYSICIAN'S NAME (Type) <i>DR. RONALD V. GECKLER</i>				23D. ADDRESS <i>33RD &amp; CALVERT STS. UNION MEM. HOSP. BALTO. MD. 21218</i>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>12/22/69</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Bohemian National Cemetery</i>	
24D. LOCATION <i>Baltimore, Md.</i>		24E. NAME OF REGISTRAR <i>Robert E. Gabley</i>		24F. FUNERAL DIRECTOR <i>Witke, 4101 Edmondson Ave., Baltimore, Md.</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>DEC 22 1969</i>		25B. NAME OF REGISTRAR <i>Robert E. Gabley</i>		25C. FUNERAL DIRECTOR <i>Witke, 4101 Edmondson Ave., Baltimore, Md.</i>	



**FUNERAL DIRECTOR: IMPORTANT**

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G-412		69 12577		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 69 12577	
<b>CERTIFICATE OF DEATH</b>							
1. NAME OF DECEASED (Type or Print)		CHARLES FRANK GLEBAS		2. DATE AND HOUR OF DEATH			
5 Was <i>fr. Frank</i>				12-19-69 14:30 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <b>35 Church Home Hospital</b>				A. STATE B. COUNTY <i>Baltimore Maryland</i>			
				C. CITY OR TOWN <i>Baltimore</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 1509	
				E. STREET AND NUMBER <i>4020 Batenon Ave</i>			
5. SEX <i>M</i>	6. RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>7-24-10</i>	9. AGE (In years last birthday) <i>59</i>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Clothing Cutter</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Tailor</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>George Glebas</i>				14. MOTHER'S MAIDEN NAME <i>Elizabeth Bucius</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>Unknown</i>		16. SOCIAL SECURITY NO. <i>215039164</i>		17. INFORMANT <i>Chas. S. Glebas Rt. 1, Box 382 Fallston Md.</i>			
18. CAUSE OF DEATH							
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)							
(A) IMMEDIATE CAUSE <i>Metastatic</i> DUE TO, OR AS A CONSEQUENCE OF:							
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.							
(B) <i>Carcinoma from Carcinoma of Stomach</i> DUE TO, OR AS A CONSEQUENCE OF:							
(C) _____							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>No</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (H) (this hospital) attended the deceased from <i>12-10-69</i> to <i>12-19-69</i> that (N) (we) lost saw the deceased alive on <i>12-19-69</i> and that (M) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (H) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>Kurtmanas</i>				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>12-19-69</i>	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS <i>Church Home Hospital</i>			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY		24D. LOCATION (City, town, or county) (State)	
<i>Burial</i>		<i>12/23/69</i>		<i>New Cathedral Cemetery</i>		<i>Baltimore, Maryland</i>	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
<i>DEC 22 1969</i>		<i>22-69</i>		<i>Wizko</i>		<i>Funeral Director, 4101 Edmondson Ave.</i>	

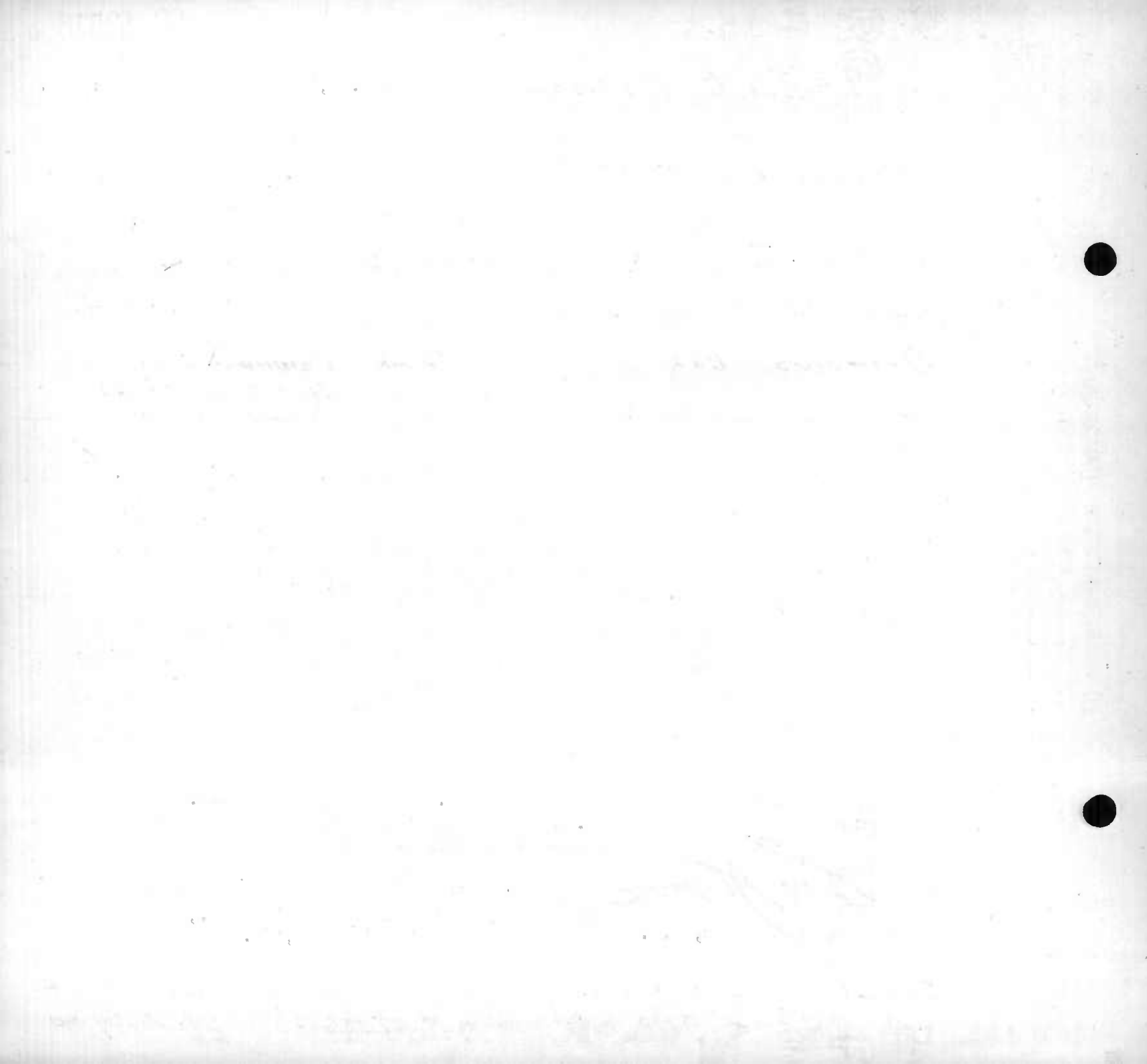




# FUNERAL DIRECTOR: IMPORTANT

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0-255 69 12578		BALTIMORE CITY HEALTH DEPARTMENT <b>CERTIFICATE OF DEATH</b>		REG. NO. 69 12578	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>LETITIA C. OSMOND</i>		2. DATE AND HOUR OF DEATH Dec. 17, 1969 5:30 A. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>2759</i>		C. CITY OR TOWN <i>Baltimore</i>	
FULL NAME OF HOSPITAL OR INSTITUTION <i>SILVER CROSS NURSING HOME</i> <i>90</i>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <i>FEMALE</i>		6. RACE <i>WHITE</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <i>12-29-76</i>		9. AGE (In years last birthday) <i>92</i>		10. UNDER 1 Yr. Months Days 11. UNDER 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>HOUSEWIFE</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>AT HOME</i>		11. BIRTHPLACE (State or foreign country) <i>Virginia</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>Octavius Cox</i>		14. MOTHER'S MAIDEN NAME <i>Corra Cowart</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>1</i>		17. INFORMANT <i>H. HUNTER</i> ADDRESS <i>1303 Northview Rd Baltimore, Md.</i>	
18. <i>440.91</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last,  <i>II</i> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		CAUSE OF DEATH (A) IMMEDIATE CAUSE Generalized Arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF:  (B) _____ DUE TO, OR AS A CONSEQUENCE OF:  (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>yrs.</i>	
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>no</i>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) <i>(not hospital)</i> attended the deceased from <i>Jan.</i> 19 <i>65</i> to <i>Dec.</i> 19 <i>69</i> , that (I) <i>(not)</i> last saw the deceased alive on <i>Dec. 16</i> 19 <i>69</i> and that in (my) <i>(not)</i> opinion death occurred on the date and hour and from the causes stated above, (I) <i>(not)</i> (did) (did not) view the body after death.		23A. SIGNATURE <i>[Signature]</i> DEGREE	
23B. DATE SIGNED <i>12/17/69</i>		23C. PHYSICIAN'S NAME (Type) <i>Leo J. Gaver, M.D.</i>		23D. ADDRESS <i>1 Mallow Hill Ave., Baltimore, Md.</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>12-20-69</i>		24C. NAME OF CEMETERY OR CREMATORY <i>GREENWAY Cem.</i>	
24D. LOCATION (City, town, or county) (State) <i>Baltimore, Md. U.S.A.</i>		25A. DATE REC'D BY HEALTH DEPT. <i>DEC 22 1969</i>		25B. NAME OF REGISTRAR <i>[Signature]</i>	
25C. FUNERAL DIRECTOR <i>[Signature]</i>		25D. ADDRESS <i>Ellie Cottrell, Md.</i>		25E. <i>[Signature]</i>	



# FUNERAL DIRECTOR: IMPORTANT

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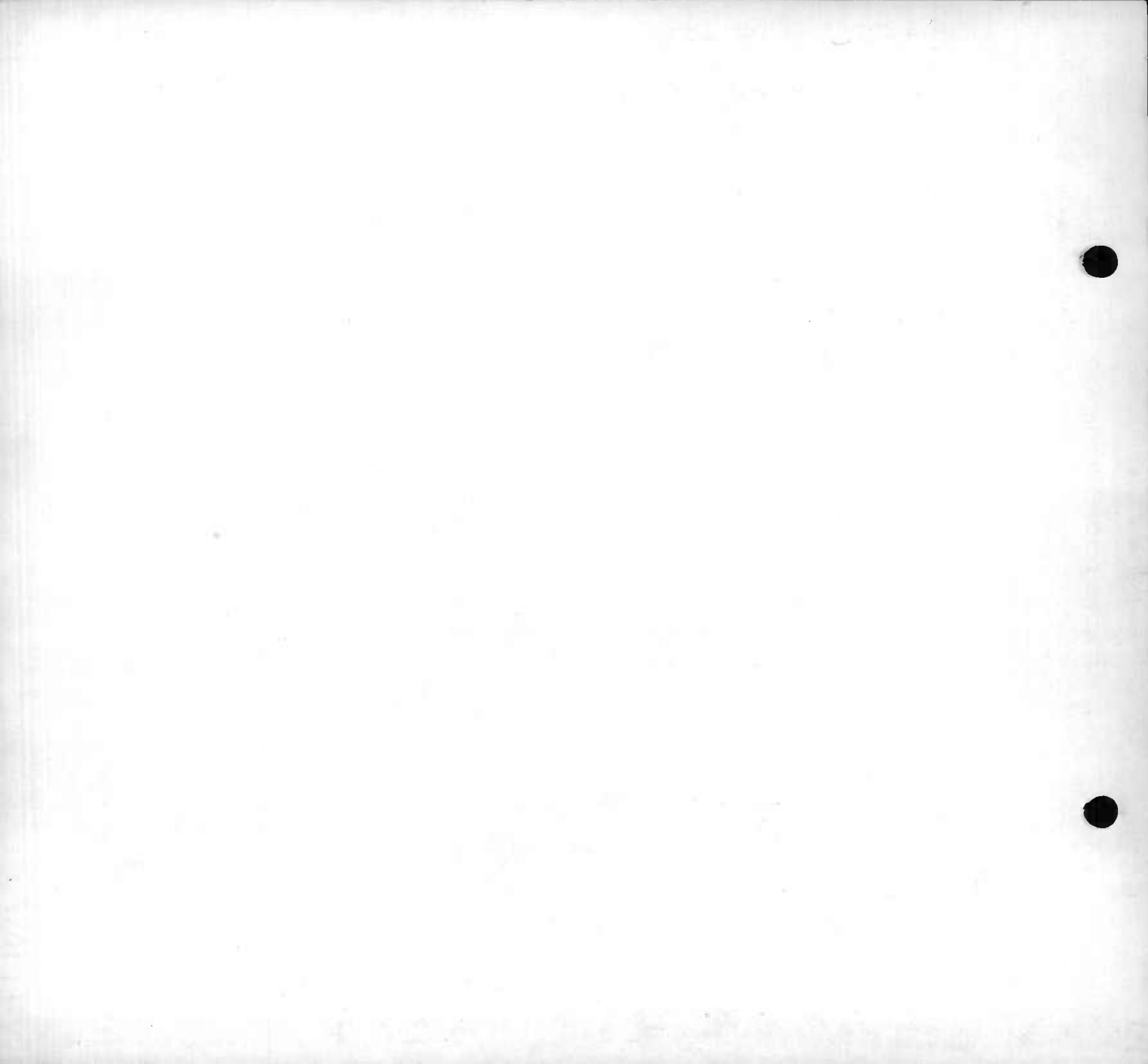
B-524		69 12579		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO.		69 12579			
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH							
		Bonsall, Sr., Charles E.		12-18-69		11:15 PM.		M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		A. STATE		B. COUNTY					
FULL NAME OF HOSPITAL OR INSTITUTION		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		Md		Balto		2802			
Bon Secours Hospital		2005 W. Fayette St 21223		C. CITY OR TOWN		D. INSIDE CITY LIMITS?		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
				E. STREET AND NUMBER		3303 Ferndale Ave					
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?				
Male	White	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	1-18-90	79	Miller	Maryland	U.S.A.				
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT			
Charles E. Bonsall		Heile		UNKNOWN		216-10-539		Charles E. Bonsall, Jr. - 3303 Ferndale Ave			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		Acute Myocardial disease		Hours					
ANTECEDENT CAUSES		(B) DUE TO, OR AS A CONSEQUENCE OF:		AS CVD		Many years					
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C)									
II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).									
19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?								
6											
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)									
21D. TIME OF INJURY (APPROX.)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?									
(Month) (Day) (Year) (Hour)	While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>										
22. I certify that (this hospital) attended the deceased from 12/12/69 to 12/18/69		that (we) last saw the deceased alive on 12/18/69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death.									
23A. SIGNATURE		23B. DATE SIGNED									
M. Abbas M.D.		12-18-69									
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS									
M. Abbas, M.D.		Bon Secours Hospital									
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY or CREMATORY	24D. LOCATION (City, town, or county)								
Burial	12-22-69	New Cathedral Cemetery	Baltimore Md								
25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS								
DEC 22 1969	Robert E. Taylor, Md.	Armadost Funeral Chapel-4600 Liberty Hts									



# FUNERAL DIRECTOR: IMPORTANT

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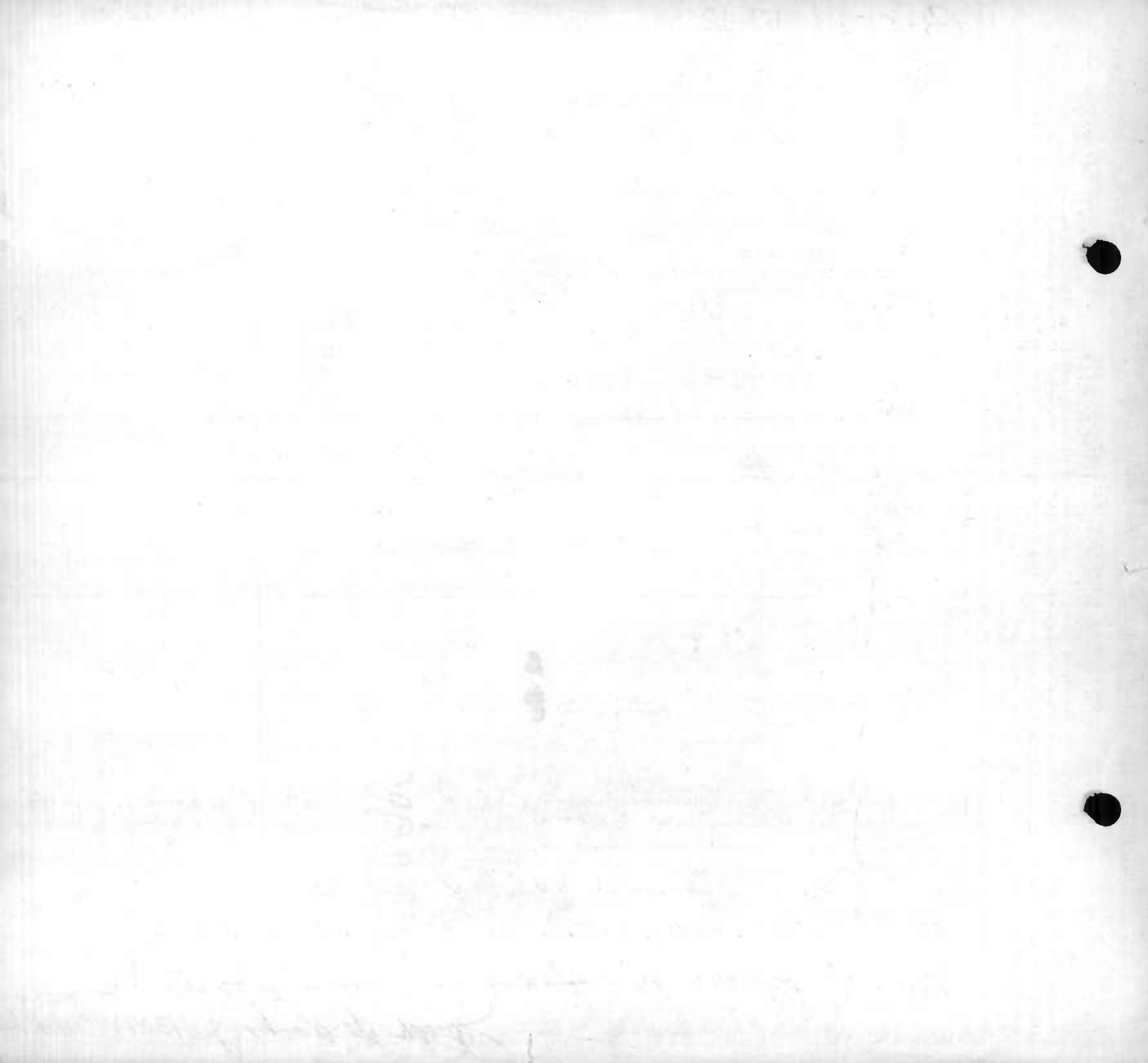
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <b>69 12580</b>	
J-250 69 12580		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>JACKSON Joseph.</b>		2. DATE AND HOUR OF DEATH <b>12-20-69 6:45 P.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>90 Harborview n.c.c.</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>md.</b> B. COUNTY <b>7</b> C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>212 N. Green St.</b>			
5. SEX <b>male</b>	6. RACE <b>C</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5-11-10</b>	9. AGE (In years last birthday) <b>59</b>	10. Under 1 Yr. Months: Days: 11. Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Construction Worker</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>S. Carolina</b>	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>718-123561</b>		17. INFORMANT <b>Mary Davis 212 N. Green St.</b>	
18. <b>436.917-250.9</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Cerebral Vase. Accident</b> <b>Cerebral arterio-sclerosis</b> (B) DUE TO, OR AS A CONSEQUENCE OF: <b>Cardiac De-compensation</b> (C) <b>Art. Sel C-V Disease</b>  APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>24 hrs.</b>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>Diabetes Mellitus, Epilepsy, H. Pseudotumor</b>					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <b>Dec. 4 1969</b> to <b>12/20 1969</b> , that (I) ( <del>was</del> ) last saw the deceased alive on <b>12/20 1969</b> and that in (my) ( <del>own</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>was</del> ) ( <del>did</del> ) view the body after death.					
23A. SIGNATURE <b>Kenneth Fulearty MD</b>		23B. DATE SIGNED <b>12/21/69</b>		23C. PHYSICIAN'S NAME (Type) <b>Kenneth Fulearty MD</b>	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY <b>Burial 122469 Mt. Auburn</b>	
24D. LOCATION (City, town, or county) (State)		24E. ADDRESS		24F. FUNERAL DIRECTOR <b>William H. Crumman</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 22 1969</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. ADDRESS <b>3302 W. NORTH AVE</b>	



## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

G-252		69 12581		BALTIMORE CITY HEALTH DEPARTMENT		69 12581	
BIRTH NO.				REG. NO.			
1. NAME OF DECEASED (Type or Print) GASKINS, Lena				2. DATE AND HOUR OF DEATH 12/17/69		ARRIVED 3:50, 12/17/69 3:50 A.M. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 843			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 33 The Johns Hopkins Hospital				C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 2722 E. <del>Chase</del> Chase Street			
5. SEX F	6. RACE NEGRO	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/9/21	9. AGE (In years last birthday) 48	If Under 1 Yr. Months: Days:	If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Packer		10B. KIND OF BUSINESS OR INDUSTRY DONUT CO		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Garfield Turnage				14. MOTHER'S MAIDEN NAME Katie Mills			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
18. 436.01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Gastrointestinal hemorrhage (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Probable esophageal varices ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (B) DUE TO, OR AS A CONSEQUENCE OF: (C)				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 3:55 Dec 17 19 69 to 4:30 Same 19 69, that (I) (we) last saw the deceased alive on Same 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Bruce S. Brown M.D. DEGREE				Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) Bruce S. Brown, M.D.				23D. ADDRESS The Johns Hopkins Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/20/69		24C. NAME of CEMETERY or CREMATORY Mt. Calvary		24D. LOCATION (City, town, or county) (State) D. A. County, Md.	
25A. DATE REC'D BY HEALTH DEPT. DEC 22 1969		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR Joseph S. Locks		ADDRESS 1304 N. Central Ave.	

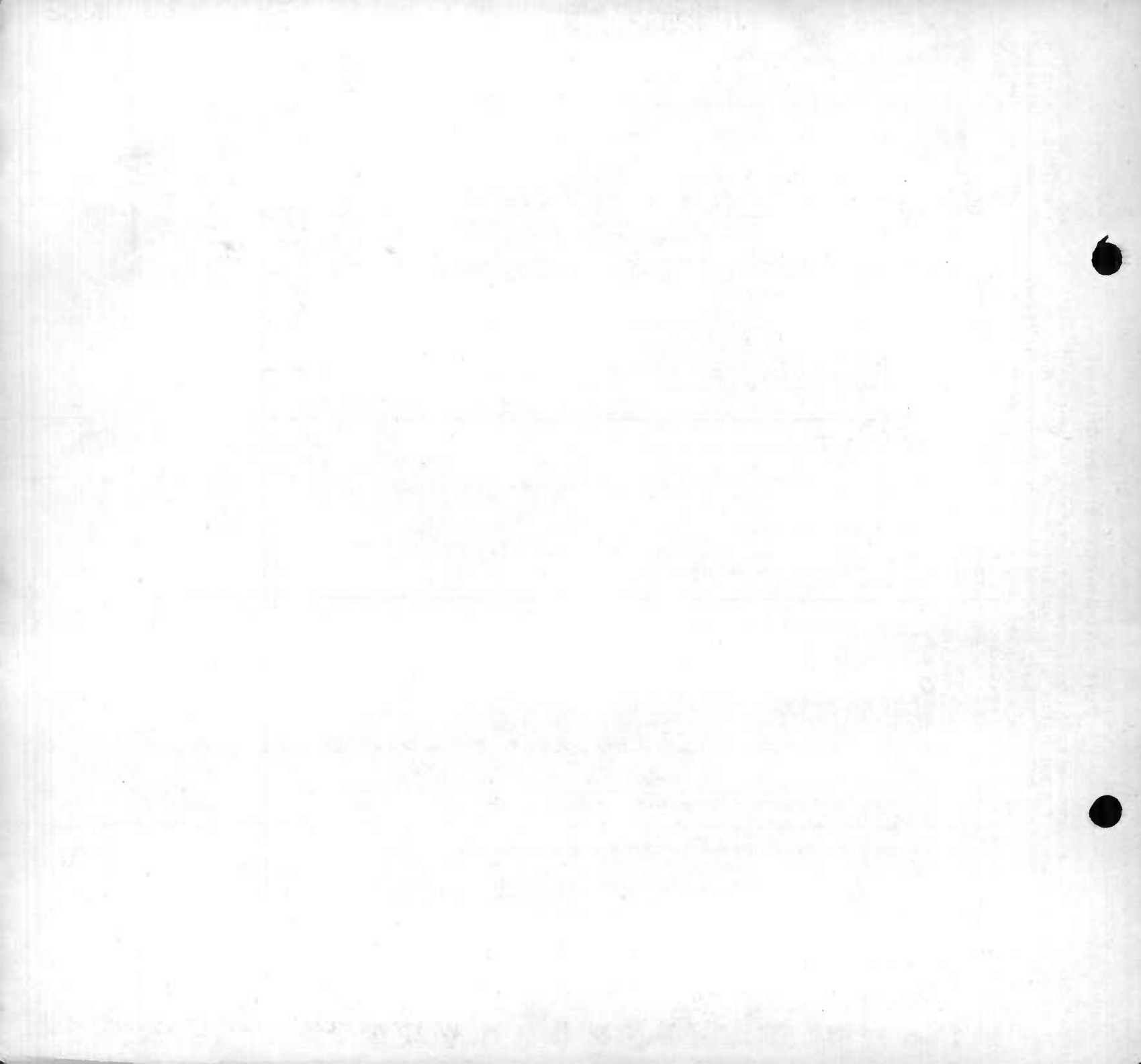




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-650 69 12582 E.				BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 69 12582	
1. NAME OF DECEASED (Type or Print) <u>Robert Brown</u>				2. DATE AND HOUR OF DEATH <u>12/15/69</u> <u>1 30</u> <u>pm.</u> <u>M.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>Melchor Nursing Home</u>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>12327 N. Charles Street</u>		A. STATE <u>MARYland</u>		B. COUNTY <u>115 W. 22nd St</u>	
				C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <u>115 W. 22nd St.</u>		<u>1206</u>	
5. SEX <u>MALE</u>	6. RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1899</u>	9. AGE (In years last birthday) <u>70</u>	If Under 1 Yr. Months: Days: Hours: Min.	If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MARYland</u>	
						12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>UNKNOWN</u>				14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>212-18-3350</u>		17. INFORMANT <u>John Wilson</u>	
				ADDRESS <u>115 W. 22nd St.</u>			
18. <u>412.4 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>Anteriosclerotic Cardiovascular Disease</u>				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Several years</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO, OR AS A CONSEQUENCE OF:			
				(C) DUE TO, OR AS A CONSEQUENCE OF:			
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) <del>(this hospital)</del> attended the deceased from <u>Dec 8</u> 19 <u>69</u> to <u>Dec 15</u> 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>Dec 13</u> 19 <u>69</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>L. M. Zimmerman MD</u>						23B. DATE SIGNED <u>12/15/69</u>	
23C. PHYSICIAN'S NAME (Type) <u>Loy M. Zimmerman MD.</u>				23D. ADDRESS <u>3202 Hartas Rd, Baltimore MD</u>			
24A. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>12/18/69</u>		24C. NAME OF CEMETERY or CREMATORY <u>1st Calvary Cem.</u>		24D. LOCATION (City, town, or county) (State) <u>Anne Arundel Cty. MD.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>DEC 22 1969</u>		25B. NAME OF REGISTRAR <u>0268 Faber, RD.</u>		25C. FUNERAL DIRECTOR <u>W. M. T. R. H.</u>		ADDRESS <u>928 E. North Ave</u>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<div style="display: flex; justify-content: space-between;"> <span>BIRTH NO. <u>L-116</u></span> <span>69 12583</span> </div>		<div style="display: flex; justify-content: space-between;"> <span>BALTIMORE CITY HEALTH DEPARTMENT</span> <span>CERTIFICATE OF DEATH</span> </div>		<div style="display: flex; justify-content: space-between;"> <span>Registered No. <u>69 12583</u></span> <span>M.</span> </div>	
1. NAME OF DECEASED (Type or Print) <b>FRANCIS LEFEVRE</b>			2. DATE AND HOUR OF DEATH <b>12-17-69</b>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)  <b>1703 Linden Ave.</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>1401</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Balto.</b> D. STREET ADDRESS (If rural, give location) <b>1703 Linden Ave.</b>		
5. SEX <b>M</b>	6. RACE <b>Colored</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Widowed</b>	8. DATE OF BIRTH <b>4-19-94</b>	9. AGE (In years last birthday) <b>75</b>	If Under 1 Yr. Months: Days:    If Under 24 Hrs. Hours: Min. 
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Seaman</b>		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>Brittish West Indies</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>Unknown</b>			14. MOTHER'S MAIDEN NAME <b>Unknown</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes    WWI</b>		16. SOCIAL SECURITY NO. <b>218-01-3872</b>	17. INFORMANT ADDRESS <b>Dorothy Ross 1703 Linden Ave.</b>		
18. <b>412.2 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) <b>Art. Del. Hypertension</b> DUE TO (B) _____ DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH <b>5-6 yrs</b>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>Bed sores</b>					
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At <input type="checkbox"/> Work		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>Jan 1965</b> to <b>Dec 17 1969</b> , that (I) (we) last saw the deceased alive on <b>Jan 16 1969</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Samuel J. Hankin</b>				23B. DATE SIGNED <b>Dec 18 1969</b>	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS <b>3079 Liberty Hwy Balto 21222</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12-22-69</b>		24C. NAME OF CEMETERY or CREMATORY <b>Balto National Cemetery Balto., Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 22 1969</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Wm C. March 928 E. North Ave.</b>	

Ator 1844

Ator

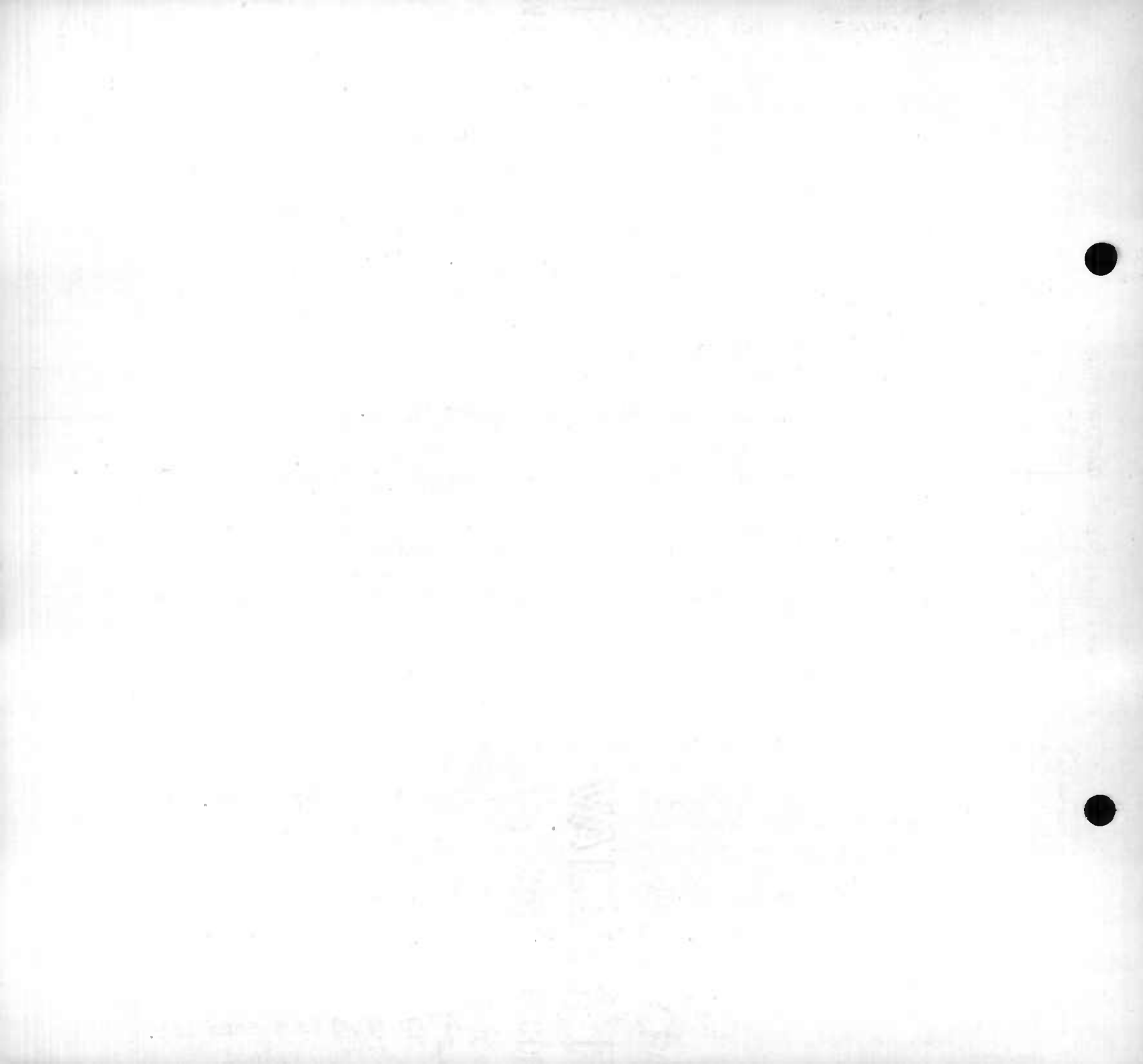
Ator 1844

Ator 1844

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

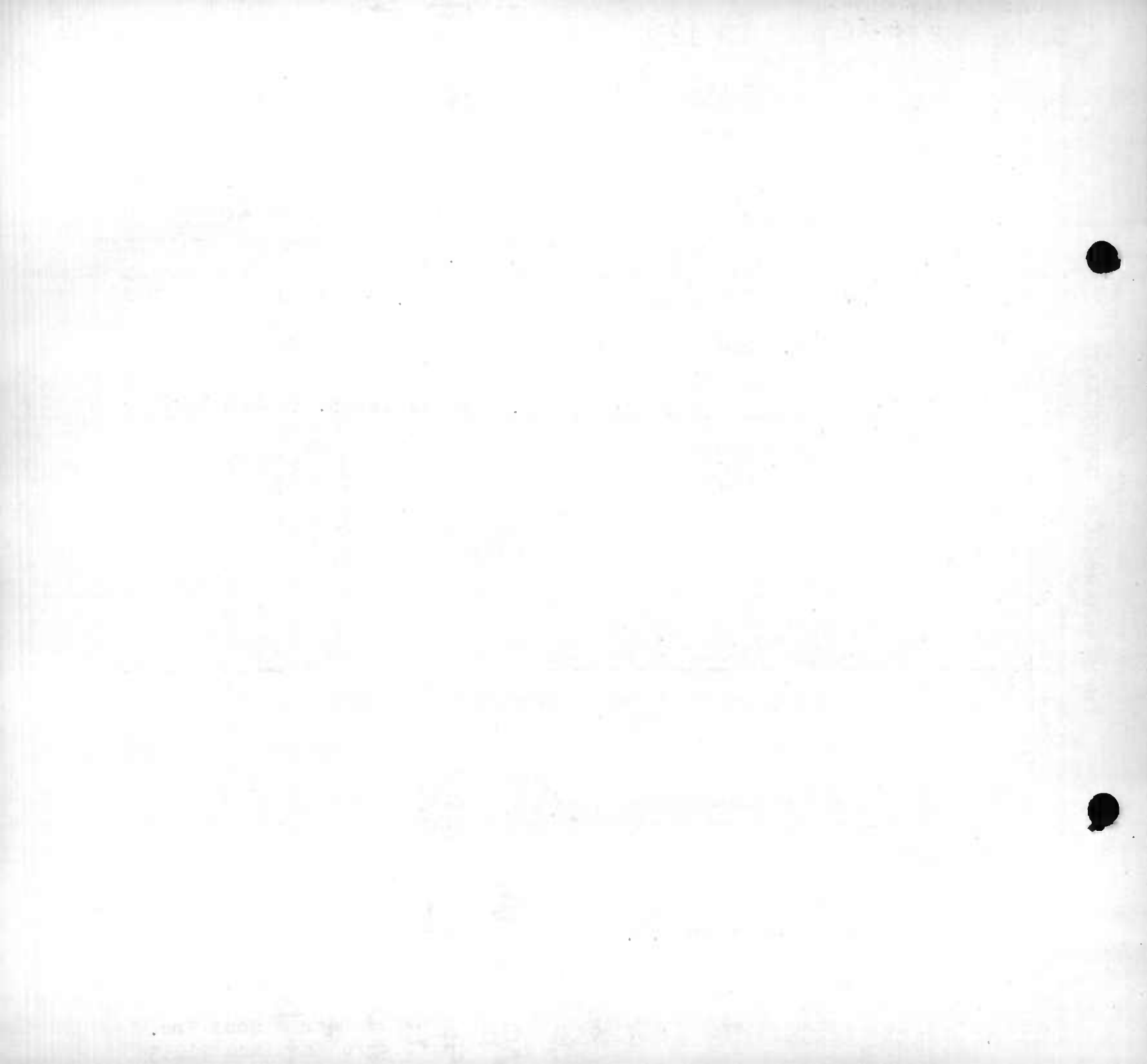
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 69 12584	
C-245 69 12584		CERTIFICATE OF DEATH			
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		THOMAS HOWELL CHISHOLM		DEC. 18, 1969 6:45 M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  3002 Hudson Street			A. STATE Maryland		
			C. CITY OR TOWN Baltimore 21224		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER 3002 Hudson Street		
5. SEX M	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 26, 1883	9. AGE (In years last birthday) 85	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Plumber		10B. KIND OF BUSINESS OR INDUSTRY Retired	11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Thomas Howell Chisholm			14. MOTHER'S MAIDEN NAME Mary Barton		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 213 10 3081	17. INFORMANT Mrs May C. Chisholm 3002 Hudson		
18. 412.41 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE Arteriosclerotic Cardio-vascular Disease DUE TO, OR AS A CONSEQUENCE OF: (B) _____ (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 yrs.
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from December 17, 19 69 to Dec. 18, 19 69, that (I) (we) last saw the deceased alive on Dec. 16, 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE Clarence W. Ledoux				23B. DATE SIGNED 12/19/69	
23C. PHYSICIAN'S NAME (Type) Clarence W. Ledoux Md.				23D. ADDRESS 3023 Eastern Avenue	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/22/69		24C. NAME OF CEMETERY or CREMATORY Woodlawn Cemetery	
				24D. LOCATION (City, town, or county) (State) Woodlawn Maryland	
25A. DATE REC'D BY HEALTH DEPT. DEC 22 1969		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR Henry Sander & Sons Inc.	
				Baltimore Maryland	



# FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>69 12585</u>	
<b>7-630</b> <b>69 12585</b>		<b>CERTIFICATE OF DEATH</b>			
<b>BIRTH NO.</b> <b>1. NAME OF DECEASED</b> (Type or Print) <u>Margaret Smith Ford</u>		<b>2. DATE AND HOUR OF DEATH</b> <u>December 16, 1969</u>			
<b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b>  <b>FULL NAME OF HOSPITAL OR INSTITUTION</b> (If not in hospital or institution, give street address or location) <u>90 Gould Nursing Home</u> <u>Belair Road</u>		<b>4. USUAL RESIDENCE</b> (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>2610</u> <b>C. CITY OR TOWN</b> <u>Baltimore</u> <b>D. INSIDE CITY LIMITS?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> <b>E. STREET AND NUMBER</b> <u>127 South East Avenue</u>			
<b>5. SEX</b> <u>F</u>	<b>6. RACE</b> <u>W</u>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>Aug. 3, 1886</u>	<b>9. AGE</b> (In years lost birthday) <u>83</u>	<b>If Under 1 Yr.</b> Months: <u>  </u> Days: <u>  </u> <b>If Under 24 Hrs.</b> Hours: <u>  </u> Min: <u>  </u>
<b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Seamstress</u>		<b>10B. KIND OF BUSINESS OR INDUSTRY</b> <u>Retired</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Balto. Maryland</u>	
<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>		<b>13. FATHER'S NAME</b> <u>John H. Ford</u>			
<b>14. MOTHER'S MAIDEN NAME</b> <u>Annie Robinson</u>		<b>15. Was Deceased Ever in U. S. Armed Forces?</b> (If yes, give war or dates of service) <u>NO</u>			
<b>16. SOCIAL SECURITY NO.</b> <u>217 01 4178 A.</u>		<b>17. INFORMANT</b> <u>Mr William B. Wooden</u> <b>ADDRESS</b> <u>3007 Oakcrest A</u>			
<b>18. CAUSE OF DEATH</b> <b>I</b> <b>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		<b>(A) IMMEDIATE CAUSE</b> <u>Acute Coronary Thrombosis</u> <b>DUE TO, OR AS A CONSEQUENCE OF:</b>  <b>(B) Anterograde Vascular Disease</b> <b>DUE TO, OR AS A CONSEQUENCE OF:</b>  <b>(C)</b>			
<b>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</b>		<b>II</b> <b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</b>			
<b>19A. DATE OF OPERATION</b> <u>0</u>	<b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b>		<b>20A. AUTOPSY?</b> (Yes or No) <u>NO</u>	<b>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</b>	
<b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner) <input type="checkbox"/>		<b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		<b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)	
<b>21D. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (APPROX.)		<b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		<b>21F. HOW DID INJURY OCCUR?</b>	
<b>22. I certify that (I) (this hospital) attended the deceased from</b> <u>June - 21 - 19 58</u> <b>to</b> <u>Dec - 16 - 19 69</u> , <b>that (I) (we) last saw the deceased alive on</b> <u>Dec - 11 - 19 69</u> <b>and that in (my) (our) opinion death occurred on the date</b> <u>Dec - 16 - 19 69</u> <b>and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</b>					
<b>23A. SIGNATURE</b> <u>William G. Geyer</u>		<b>23B. PHYSICIAN'S NAME</b> (Type) <u>William Geyer M.D.</u>		<b>23C. DATE SIGNED</b> <u>Dec. 18-69</u>	
<b>23D. ADDRESS</b> <u>156 North Milton Avenue</u>		<b>24. BURIAL CREMATION, REMOVAL</b> (Specify) <u>Burial</u>			
<b>24B. DATE</b> <u>12/19/69</u>		<b>24C. NAME OF CEMETERY or CREMATORY</b> <u>Oak Lawn</u>		<b>24D. LOCATION</b> (City, town, or county) (State) <u>Baltimore Maryland</u>	
<b>25A. DATE REC'D BY HEALTH DEPT.</b> <u>DEC 22 1969</u>		<b>25B. NAME OF REGISTRAR</b> <u>Henry Sander</u>		<b>25C. FUNERAL DIRECTOR</b> <u>Henry Sander &amp; Sons Inc.</u> <b>ADDRESS</b> <u>Baltimore Maryland 21213</u>	

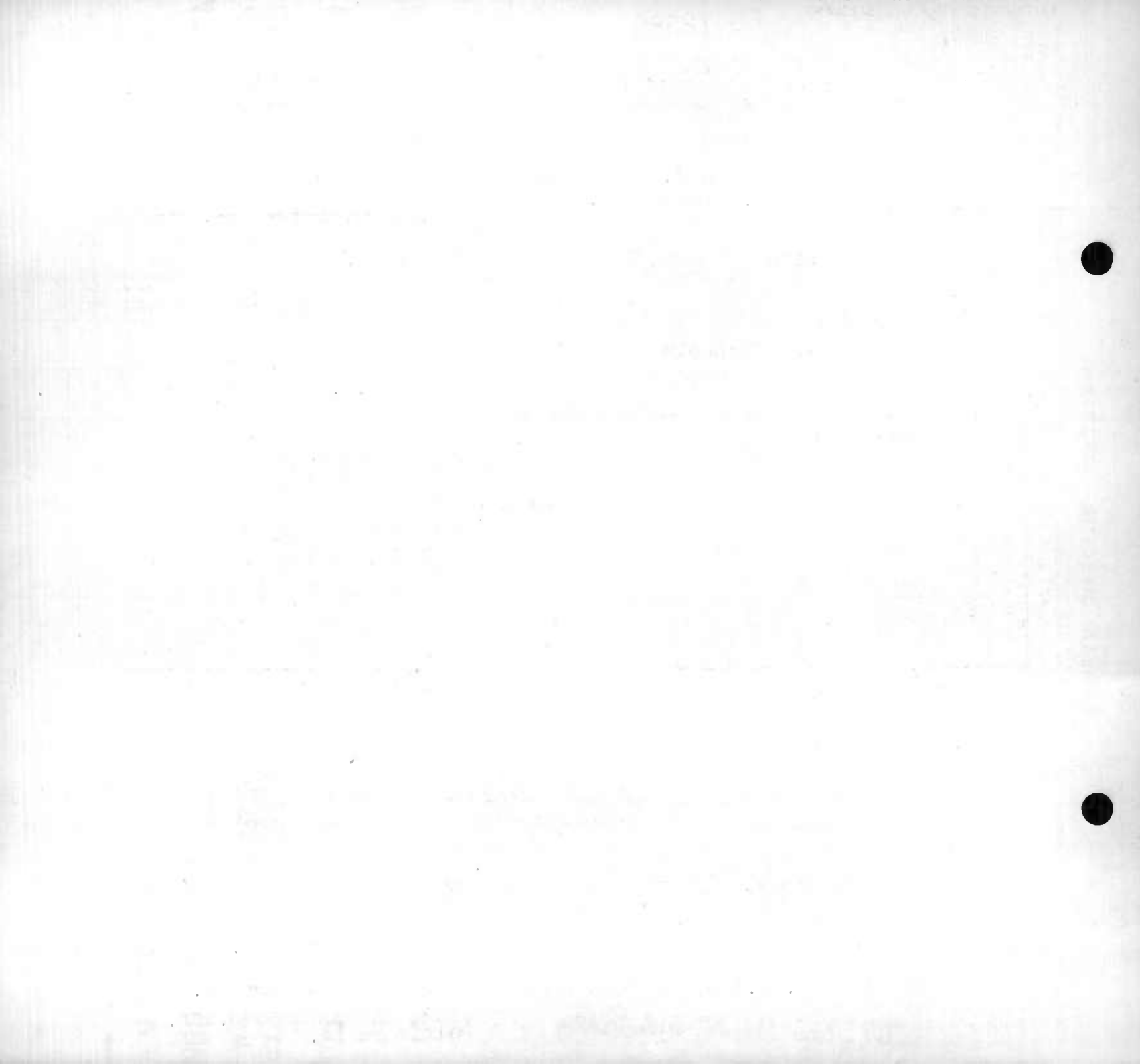




FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<p><b>B-655</b>      <b>69 12586</b>      <b>BALTIMORE CITY HEALTH DEPARTMENT</b></p> <p style="font-size: 1.2em; font-weight: bold;">CERTIFICATE OF DEATH</p>		<p>REG. NO. <b>69 12586</b></p>	
<p><b>BIRTH NO.</b></p>		<p><b>1. NAME OF DECEASED (CHARLOTTE BROWNING)</b> (Type or Print) <b>Lottie Browning</b></p>	
<p><b>2. DATE AND HOUR OF DEATH</b> <b>December 17, 1969</b>      <b>7.50 AM</b> M.</p>		<p><b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b></p>	
<p><b>4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)</b> A. STATE <b>Maryland</b>      B. COUNTY <b>2402</b></p>		<p><b>5. FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)</b> <b>Long Green Nursing Home</b> <b>115 E. Melrose Ave.</b></p>	
<p><b>6. CITY OR TOWN</b> <b>Baltimore 21230</b>      <b>7. INSIDE CITY LIMITS?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></p>		<p><b>8. STREET AND NUMBER</b> <b>1159 Riverside Ave.</b></p>	
<p><b>9. SEX</b> <b>Female</b></p>	<p><b>10. RACE</b> <b>White</b></p>	<p><b>11. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/></p>	<p><b>12. DATE OF BIRTH</b> <b>December 30, 1880</b> <b>88</b></p>
<p><b>13. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)</b> <b>Housewife</b></p>		<p><b>14. KIND OF BUSINESS OR INDUSTRY</b> <b>at Home</b></p>	
<p><b>15. BIRTHPLACE (State or foreign country)</b> <b>Baltimore Maryland</b></p>		<p><b>16. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b></p>	
<p><b>17. FATHER'S NAME</b> <b>Adolf Jochheim</b></p>		<p><b>18. MOTHER'S MAIDEN NAME</b> <b>Sophia Bartel</b></p>	
<p><b>19. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)</b> <b>NO</b></p>		<p><b>20. SOCIAL SECURITY NO.</b> <b>217-38-2867B</b></p>	
<p><b>21. INFORMANT</b> <b>P.O. Box 493 Severn Park MD.</b></p>		<p><b>22. ADDRESS</b> <b>Mrs Catherine Wood Smith</b></p>	
<p><b>23. I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)</p>		<p><b>24. CAUSE OF DEATH</b> <b>Arterio sclerotic C.V. Disease</b> <b>Leading to Myelitis</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Malnutrition</b> (B) DUE TO, OR AS A CONSEQUENCE OF: <b>Multiple pressure ulcers</b> (C) <b>and fracture Rt Hip</b></p>	
<p><b>25. ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p>		<p><b>26. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</b> <b>Many years</b></p>	
<p><b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</b></p>			
<p><b>27. DATE OF OPERATION</b> <b>0</b></p>	<p><b>28. CONDITION FOR WHICH OPERATION WAS PERFORMED</b></p>	<p><b>29. AUTOPSY? (Yes or No)</b> <b>No</b></p>	<p><b>30. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</b></p>
<p><b>31. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)</b> <b>No</b></p>	<p><b>32. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</b></p>	<p><b>33. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)</p>	
<p><b>34. TIME OF INJURY (APPROX.)</b> (Month) (Day) (Year) (Hour)</p>	<p><b>35. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>	<p><b>36. HOW DID INJURY OCCUR?</b></p>	
<p><b>37. I certify that (I) (this hospital) attended the deceased from</b> <b>Approx 4 years</b> <b>19</b> <b>to</b> <b>12/17/69</b> <b>19</b> that (I) (we) last saw the deceased alive on <b>12/15/69</b> <b>19</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</p>			
<p><b>38. SIGNATURE</b> <b>George McLean</b></p>		<p><b>39. DATE SIGNED</b> <b>12/17/69</b></p>	
<p><b>40. PHYSICIAN'S NAME (Type)</b> <b>GEORGE McLEAN</b></p>		<p><b>41. ADDRESS</b> <b>Medical Arts Bldg. Baltimore Md</b></p>	
<p><b>42. BURIAL CREMATION, REMOVAL (Specify)</b> <b>Burial</b></p>	<p><b>43. DATE</b> <b>Dec. 20. 1969</b></p>	<p><b>44. NAME OF CEMETERY OR CREMATORY</b> <b>Loudon Park Cemetery</b></p>	<p><b>45. LOCATION (City, town, or county) (State)</b> <b>Baltimore Md.</b></p>
<p><b>46. DATE REC'D BY HEALTH DEPT.</b> <b>DEC 22 1969</b></p>	<p><b>47. NAME OF REGISTRAR</b> <b>Robert E. Taylor, M.D.</b></p>	<p><b>48. FUNERAL DIRECTOR</b> <b>HENRY SANDER &amp; SONS, INC.</b></p>	
<p><b>49. ADDRESS</b> <b>Baltimore Md.</b></p>		<p><b>50. ADDRESS</b></p>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

L-520 69 12587				BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 69 12587	
1. NAME OF DECEASED (Type or Print) <b>DAVID C. LANG, Jr.</b>				2. DATE AND HOUR OF DEATH <b>December 18, 1969</b> <span style="float: right;">A. M.</span>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>00 5936 Glenkirk Road</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>2748</b> C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>5936 Glenkirk Road - 21212</b>			
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 10, 1905</b>	9. AGE (In years lost birthday) <b>64</b>	If Under 1 Yr. Months: Days: Hours: Min.	If Under 24 Hrs. Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Grocer</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>David C. Lang</b>				14. MOTHER'S MAIDEN NAME <b>Frieda Klotz</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>215-09-2020</b>		17. INFORMANT ADDRESS <b>Mrs. Margaret Lang-5936 Glenkirk Rd.</b>			
18. CAUSE OF DEATH I <b>412.3</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Anterolateral Heart Attack With Emphysema.</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Chronic Obstructive Lung Disease</b> II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>Peptic Ulcer with Hypertension</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Years Over 10</b> <b>8 years.</b>			
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notably medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>Jan 1964</b> to <b>18 Dec 1969</b> , that (I) (we) last saw the deceased alive on <b>18 Dec 1969</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Lauriston L. Keown</b>				23B. DATE SIGNED <b>18 Dec 1969</b>		23C. PHYSICIAN'S NAME (Type) <b>Lauriston L. Keown, M.D.</b>	
23D. ADDRESS <b>431 E. Lake Avenue - 21212</b>		24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>					
24B. DATE <b>12/22/69</b>		24C. NAME OF CEMETERY or CREMATORY <b>Moreland Memorial Park</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 22 1969</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor, M.D.</b>		25C. FUNERAL DIRECTOR ADDRESS <b>H. Sander &amp; Sons, Inc., Balto., Md.</b>			

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James H. Thompson

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-520 69 12588		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 69 12588	
BIRTH NO.					
1. NAME OF DECEASED (Type or Print) <b>BANKS, MRS. FLORA</b>			2. DATE AND HOUR OF DEATH <b>12-19-69 4:45 A. M.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <b>34 Bon Secours Hospital</b>			A. STATE <b>MD.</b> B. COUNTY <b>1603</b>		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			C. CITY OR TOWN <b>Baltimore</b>		
			D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
			E. STREET AND NUMBER <b>745 N. Fulton Ave.</b>		
5. SEX <b>F</b>	6. RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12/05/27</b>	9. AGE (In years last birthday) <b>42</b>	10. CITIZEN OF WHAT COUNTRY <b>U.S.A</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		
10B. KIND OF BUSINESS OR INDUSTRY			12. CITIZEN OF WHAT COUNTRY <b>U.S.A</b>		
13. FATHER'S NAME <b>Anthony Lawrence</b>			14. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>			16. SOCIAL SECURITY NO. <b>Admission Sheet</b>		
17. INFORMANT ADDRESS					
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>250.0 H-320.9</b>			CAUSE OF DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE <b>DIABETIC KETOSIS, MENINGITIS</b> DUE TO, OR AS A CONSEQUENCE OF:		
			(B) <b>PELVIC INFLAMMATORY DISEASE + SEPTICEMIA</b> DUE TO, OR AS A CONSEQUENCE OF:		
			(C) _____		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>12-14</b> 19 <b>69</b> to <b>December 19</b> 19 <b>69</b> and that (I) (we) last saw the deceased alive on <b>December 19</b> 19 <b>69</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Orathai Thirawat</b> MD DEGREE				23B. DATE SIGNED <b>12/19/69</b>	
23C. PHYSICIAN'S NAME (Type) <b>ORATHAI THIRAWAT MD</b>				23D. ADDRESS <b>BON SECOURS HOSPITAL, BALTO MD 23.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <b>12/23/69</b>		24C. NAME OF CEMETERY or CREMATORY <b>Greenwood</b>	
24D. LOCATION (City, town, or county) (State)		24E. NAME OF REGISTRAR <b>Robert C. Taylor</b>		24F. FUNERAL DIRECTOR <b>Robert C. Taylor</b>	
24G. DATE RECEIVED BY HEALTH DEPT. <b>DEC 22 1969</b>		24H. NAME OF REGISTRAR <b>Robert C. Taylor</b>		24I. FUNERAL DIRECTOR <b>Robert C. Taylor</b>	



1  
H-536 69 12589 BALTIMORE CITY HEALTH DEPARTMENT  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH REG. NO. 69 12589

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>WILLIAM HENDERSON</b>		2. DATE OF DEATH Known <input type="checkbox"/> Estimated <input type="checkbox"/> <b>12/18/69 2:40 p.m.</b>	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>East side of Pier #8 - Canton</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>December 18, 1969 2:40 p.m.</b>	
6. SEX <b>Male</b>		7. RACE <b>Negro</b>	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Balto.</b>	
9. DATE OF BIRTH <b>6/11/21</b>		10. AGE (in years last birthday) <b>48</b>	
11. BIRTHPLACE (State or foreign country) <b>Va.</b>		12. CITIZEN OF <b>U.S.A.</b>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>yes 4/7/43 to 11/22/42</b>		17. SOCIAL SECURITY NO. <b>14 8046</b>	
18. INFORMANT <b>Elsie Henderson</b>		ADDRESS <b>2515 Fairmount Ave.</b>	
19. <b>E 91019</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>45</b> <b>CAUSE OF DEATH</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>(A) IMMEDIATE CAUSE Drowning</b> <b>DUE TO, OR AS A CONSEQUENCE OF:</b> <b>(b)</b> <b>(c)</b>			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Water</b>	
22D. TIME OF INJURY (APPROX.) <b>12 18 69 12:05</b>		22E. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>Pier 8 Lower Canton, S of Newgate, E of Grundy</b>		22F. HOW DID INJURY OCCUR? <b>Accidentally backed tractor into harbor</b>	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		21. AUTOPSY? (Yes or No) <b>YES</b>	
ACTUAL SIGNATURE <b>Isidore Mihalakis, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12/23/69</b>	
24C. NAME OF CEMETERY OR CREMATORY <b>Balto. Natl. Cem.</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 22 1969</b>		25B. NAME OF REGISTRAR <b>J. E. Baker</b>	
25C. FUNERAL DIRECTOR <b>Kelson Funeral Home</b>		ADDRESS <b>1348 N. Calhoun</b>	

1. The purpose of this document is to provide information regarding the activities of the [redacted] and the [redacted] in the [redacted] area.

2. The [redacted] has been identified as a [redacted] and is currently [redacted] in the [redacted] area.

3. The [redacted] has been identified as a [redacted] and is currently [redacted] in the [redacted] area.

4. The [redacted] has been identified as a [redacted] and is currently [redacted] in the [redacted] area.

5. The [redacted] has been identified as a [redacted] and is currently [redacted] in the [redacted] area.

6. The [redacted] has been identified as a [redacted] and is currently [redacted] in the [redacted] area.

7. The [redacted] has been identified as a [redacted] and is currently [redacted] in the [redacted] area.

8. The [redacted] has been identified as a [redacted] and is currently [redacted] in the [redacted] area.

9. The [redacted] has been identified as a [redacted] and is currently [redacted] in the [redacted] area.

10. The [redacted] has been identified as a [redacted] and is currently [redacted] in the [redacted] area.

11. The [redacted] has been identified as a [redacted] and is currently [redacted] in the [redacted] area.



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <u>69 12580</u>	
A-325 69 12580		CERTIFICATE OF DEATH	
BIRTH NO.		2. DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print) <u>ATKINS, RACHEL</u>		<u>December 20, 1969</u> <u>11:30</u> <u>A.M.</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION <u>SINAI HOSPITAL OF BALTIMORE</u> <u>42</u>		A. STATE <u>MD.</u> B. COUNTY <u>1510</u>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <u>BALTIMORE</u>	
		D. INSIDE CITY LIMITS? <u>YES</u> <input checked="" type="checkbox"/> <u>NO</u> <input type="checkbox"/>	
		E. STREET AND NUMBER <u>4103 Chatham Rd #7.</u>	
5. SEX <u>F.</u>	6. RACE <u>N.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/4/93</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		9. AGE (In years last birthday) <u>76</u>	11. BIRTHPLACE (State or foreign country) <u>VIRGINIA.</u>
10B. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George Jefferson</u>		14. MOTHER'S MAIDEN NAME <u>Martha</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>330-48-5185</u>	
		17. INFORMANT <u>Rev. Frederick Atkins</u> ADDRESS <u>4103 Chatham Rd.</u>	
18. <u>412.41</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>CEREBRO-VASCULAR ACCIDENT.</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>ARTERIOSCLEROTIC CARDIOVASCULAR</u> DUE TO, OR AS A CONSEQUENCE OF: <u>DISEASE.</u> (C) _____	
19. DATE OF OPERATION <u>0</u>		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While <input type="checkbox"/> Work At Work	
21F. HOW DID INJURY OCCUR?			
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>December 19</u> <u>1969</u> to <u>December 20</u> <u>1969</u> that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>December 20</u> <u>1969</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <u>[Signature]</u>		23B. DATE SIGNED <u>December 20, 1969</u>	
23C. PHYSICIAN'S NAME (Type) <u>ANDREAS A. PETSAS</u> M.D.		23D. ADDRESS <u>SINAI HOSPITAL OF BALTIMORE</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>12/24/69</u>	
24C. NAME OF CEMETERY OR CREMATORY <u>Arlington Mt. H.</u>		24D. LOCATION (City, town, or county) (State) <u>Arlington Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>DEC 22 1969</u>		25B. NAME OF REGISTRAR <u>PERSON</u>	
25C. FUNERAL DIRECTOR <u>PERSON</u>		ADDRESS <u>1348 N. E. 11th St</u>	

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DEPARTMENT OF CHEMISTRY

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

## BALTIMORE CITY HEALTH DEPARTMENT 69 12591 CERTIFICATE OF DEATH

REG. NO.

69 12591

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>ORAZIO MASSONI</u>		2. DATE AND HOUR OF DEATH <u>3 30 12-19-69</u> A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>2634</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>Union Memorial Hosp.</u>		C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <u>5066 Wright Ave.</u>					
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-28-18</u>	9. AGE (In years last birthday) <u>51</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Mfr</u>		11. BIRTHPLACE (State or foreign country) <u>I + A / Y</u>	
12. CITIZEN OF WHAT COUNTRY? <u>I + A / Y</u>					
13. FATHER'S NAME <u>Liborio Massoni</u>		14. MOTHER'S MAIDEN NAME <u>MARY UNKNOWN</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>None</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Sister</u> ADDRESS <u>Same</u>	
18. <u>560.9 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>CARDIAC ARREST</u> (B) <u>post op intestinal obstr.</u> DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <u>12/17/69</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Bad</u>		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) 1 (Month) 2 (Day) 3 (Year) 4 (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>12/16</u> 19 <u>69</u> to <u>12/19</u> 19 <u>69</u> that (I) (we) last saw the deceased alive on <u>12/18</u> 19 <u>69</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>[Signature]</u> M.D.		23B. DATE SIGNED <u>12/19/69</u>			
23C. PHYSICIAN'S NAME (Type) <u>Enrico E. Fossi M.D.</u>		23D. ADDRESS <u>Union Memorial Hospital</u>			
24A. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>12/22/69</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Greenwood Cemetery</u>	
24D. LOCATION (City, town, or county) (State) <u>Md.</u>					
25A. DATE RECD BY HEALTH DEPT. <u>DEC 22 1969</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>		25C. FUNERAL DIRECTOR <u>Frank Della Noce</u> ADDRESS <u>372 S. High</u>	



F-6201

## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

69 12592

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO.

69 12592

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>Rose Ferracci</b>		2. DATE AND HOUR OF DEATH <b>16 Dec 69 1445 A.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>Baltimore</b>		5. FULL NAME OF HOSPITAL OR INSTITUTION <b>Mercy Hospital</b>	
6. SEX <b>F</b>		7. RACE <b>W</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH <b>10/8/16</b>		10. AGE (in years last birthday) <b>52</b>		11. Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Waitress</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>FRANK Rocca</b>		14. MOTHER'S MAIDEN NAME <b>Cynthia Ferracci</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>213-10-9993</b>		17. INFORMANT <b>M. Dominick Ferracci 1301 Broening Highway</b>	
18. <b>442X1</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) slowing the UNDERLYING CONDITION lost.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Cerebral Edema</b>		(B) <b>Intracerebral Aneurysm</b> DUE TO, OR AS A CONSEQUENCE OF:	
(C)					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>8 Dec 69</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Intracerebral Aneurysm</b>		20A. AUTOPSY? (Yes or No) <b>Yes No</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>15 Dec 69</b> to <b>16 Dec 69</b> and that (I) (we) last saw the deceased alive on <b>15 Dec 69</b> and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Edward D. Layne MD</b>		23B. DATE SIGNED <b>16 Dec 69</b>			
23C. PHYSICIAN'S NAME (Type) <b>Edward D. Layne</b>		23D. ADDRESS <b>Mercy Hospital</b>			
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>12/19/69</b>		24B. DATE <b>12/19/69</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Garden of Faith Balto.</b>	
24D. LOCATION <b>Md.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>DEC 22 1969</b>		25B. NAME OF REGISTRAR <b>Robert E. Fisher, M.D.</b>	
25C. FUNERAL DIRECTOR <b>5517 Park Ave 312</b>		25D. ADDRESS <b>High St.</b>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>69 12593</u>
BIRTH NO. <u>69 12593</u>		CERTIFICATE OF DEATH		
1. NAME OF DECEASED (Type or Print) <b>STAUDEN MAIER, JOHN, J.</b>		2. DATE AND HOUR OF DEATH <b>12-20-1969 7:35 A.M.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <b>UNION MEMORIAL HOSPITAL</b>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MARYLAND</b> U.S.A. <b>2611</b> C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>927 S. BOULDIN STREET, 21224</b>		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>UNION MEMORIAL HOSPITAL</b>				
5. SEX <b>MALE</b>	6. RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8-10-1897</b>	9. AGE (In years last birthday) <b>72</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>LABORER</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				
13. FATHER'S NAME <b>LOUIS STAUDENMAIER</b>		14. MOTHER'S MAIDEN NAME <b>JENNIE DAUM</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>212-10-1731A</b>		17. INFORMANT <b>EVA E. STAUDENMAIER</b>
18. <b>441.2 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>Exsanguination</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Leakage Aorto-Femoral graft</b> <b>Aneurysm of Aorta</b> <b>CS</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION <b>12-18-1969</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>ANEURYSM OF BILAT. FEMORAL ART.</b>		20A. AUTOPSY? (Yes or No) <b>NO</b>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>INJURY OCCUR?</b>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <b>12-16</b> 19 <b>69</b> to <b>12-20</b> 19 <b>69</b> that (I) (we) last saw the deceased alive on <b>7:35 AM 12-20</b> 19 <b>69</b> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <b>Kasuke Tsujimoto, M.D.</b>		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>12-20-1969</b>
23C. PHYSICIAN'S NAME (Type) <b>KASUKE TSUJIMOTO M.D.</b>		23D. ADDRESS <b>UNION MEMORIAL HOSPITAL 33 RD &amp; CALVERT STREET, BALTIMORE MD</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>	24B. DATE <b>12-23-69</b>	24C. NAME of CEMETERY or CREMATORY <b>SACRED HEART CEM.</b>		24D. LOCATION (City, town, or county) (State) <b>7401 GERMAN HILL RD. BALTO. CO., MD.</b>
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 22 1969</b>		25B. NAME OF REGISTRAR <b>Robert E. Fisher, M.D.</b>		25C. FUNERAL DIRECTOR <b>Charles S. Fisher</b>
				ADDRESS <b>901 S. CONKLING ST. BALTO., 21224, MD.</b>

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69 12594

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

69 12594

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>INEZ KEENE</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>LUTHERAN HOSPITAL (DOA)</b>		3. DATE PRONOUNCED DEAD Month Day Year <b>December 21, 1969</b> Hour <b>12:55 A.</b> M.	
5. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>1602</b>			
6. SEX <b>Female</b>	7. RACE <b>Negro</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	C. CITY OR TOWN <b>Baltimore</b>
9. DATE OF BIRTH <b>June 24, 1931</b>		10. AGE (In years lost birthday) <b>38</b>	D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
11. BIRTHPLACE (State or foreign country) <b>BALTO MD</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	E. STREET AND NUMBER <b>805 N. Gilmore Street</b>
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Domestic</b>		14B. KIND OF BUSINESS OR INDUSTRY	13. FATHER'S NAME <b>FLORIAN MITCHELL</b>
15. MOTHER'S MAIDEN NAME <b>FLORIAN WILSON</b>		18. INFORMANT <b>FLORIAN MITCHELL 805 N. GILMORE ST</b>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.	19. <b>E890X1</b>
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH (A) IMMEDIATE CAUSE <b>Conflagration</b> DUE TO, OR AS A CONSEQUENCE OF: (B) _____ DUE TO, OR AS A CONSEQUENCE OF: (C) _____	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>House</b>	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? <b>1641 W. Lanvale Street</b>		22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) <b>12-21-69 12:47 A.m.</b>	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? <b>Conflagration</b>	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) <b>Isidore Mihalakis, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>12/21/69</b>	
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE <b>12/24/69</b>	24C. NAME OF CEMETERY or CREMATORY <b>MT AUBURN</b>	24D. LOCATION (City, town, or county) (State) <b>BALTIMORE</b>
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 22 1969</b>	25B. NAME OF REGISTRAR <b>John E. Taylor, M.D.</b>	25C. FUNERAL DIRECTOR <b>Barbara P. Long</b>	ADDRESS <b>188 N. York</b>

100-100000

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

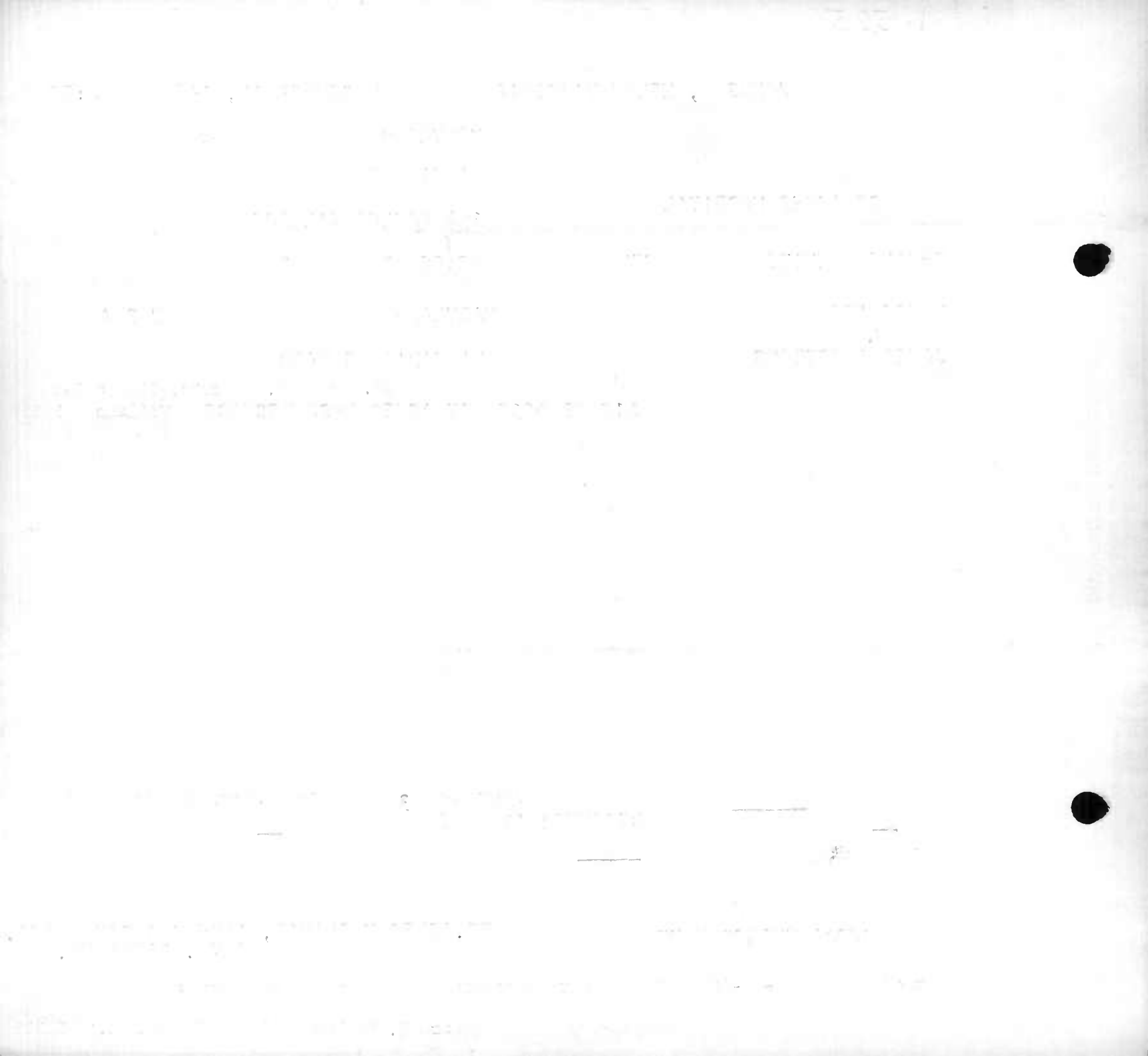
BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		REG. NO. 69 12595	
W-425 BIRTH NO. 63-24384 69 12595					
1. NAME OF DECEASED (Type or Print) WILSON TANIA R.		2. DATE AND HOUR OF DEATH 12/20/69 1:51 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) University Hospital		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY ANNE ARUNDEL 52.10 C. CITY OR TOWN ANNAPOLIS D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 84 COLLEGE CREEK TER.			
5. SEX F	6. RACE NEGRO	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/9/63	9. AGE (in years last birthday) 6	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME CHARLES WILSON		14. MOTHER'S MAIDEN NAME MARVIS WILLIAMS	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS MOTHER 84 College Cr. Ter.	
18. 398 X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) PANCARDITIS ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: RHEUMATIC FEVER (SUSPECTED) (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from DEC 18 19 69 to DEC 20 19 69 that (I) (we) last saw the deceased alive on DEC 20 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Robert L. Gingle		23B. DATE SIGNED DEC 20, 1969			
23C. PHYSICIAN'S NAME (Type) ROBERT L. GINGLE MD		23D. ADDRESS UNIVERSITY OF MARYLAND HOSP. BALD.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12-22-69		24C. NAME OF CEMETERY OR CREMATORY Pine Lawn	
24D. LOCATION Annapolis Md.					
25A. DATE REC'D BY HEALTH DEPT. DEC 22 1969		25B. NAME OF REGISTRAR Robert E. Taylor, Md.		25C. FUNERAL DIRECTOR William Reese # Anna. Md.	



# FUNERAL DIRECTOR: IMPORTANT

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J-525		69 12596		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		X REG. NO.		69 12596			
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH							
JOHNSON, HELEN VIRGINIA				DECEMBER 17, 1969 8:30 PM							
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)							
FULL NAME OF HOSPITAL OR INSTITUTION  40 ST AGNES HOSPITAL				A. STATE		B. COUNTY					
				MARYLAND		Baltimore					
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				C. CITY OR TOWN		D. INSIDE CITY LIMITS?					
				BALTIMORE		YES <input type="checkbox"/> NO <input type="checkbox"/>					
				E. STREET AND NUMBER							
				194 OAKLEE VILLAGE							
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH		9. AGE (In years last birthday)	If Under 1 Yr. Months: Days		If Under 24 Hrs. Hours: Min.			
FEMALE	WHITE	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	05 05 87		82						
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country)			
HOUSEWIFE								MARYLAND			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME							
JAMES ARMSTRONG				VIRGINIA KENNARD							
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT					
				215 03 9035		Mrs. Helen J. Roberts, 194 Oaklee Village 21229					
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				I Cancer of Sigmoid Colon (A) IMMEDIATE CAUSE WITH ANTICIPATION DUE TO, OR AS A CONSEQUENCE OF: Heart condition - myocardial infarction! (B) DUE TO, OR AS A CONSEQUENCE OF: (C)							
										ANTECEDENT CAUSES	
										DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).											
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
				NO							
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?		(If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?							
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>									
22. I certify that (I) (this hospital) attended the deceased from NOVEMBER 3 1969 to DECEMBER 17 1969 that (I) (we) last saw the deceased alive on DECEMBER 17 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE				23B. DATE SIGNED							
JESDA MUANGSOMBUT				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		12-17-69					
				DEGREE							
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS							
				ST. AGNES HOSPITAL, WILKENS & CATON AVE. BALTO. 21229 MD							
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY		24D. LOCATION					
Burial		12-20-1969		Loudon Park Cemetery		Baltimore, Maryland					
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS					
DEC 22 1969		Robert E. Taylor, R.D.		Howard H. Hubbard, 4107 Wilkens Ave.		21229					



# FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="font-size: 1.5em;">69 12597</span>	
<div style="display: flex; justify-content: space-between;"> <span style="font-size: 1.5em;">7-520 69 12597</span> <span style="font-size: 1.5em;">CERTIFICATE OF DEATH</span> </div>					
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		CATHERINE A. THOMAS		December 17, 1969	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION  <span style="font-size: 1.5em;">00</span> 271 Oaklee Village Baltimore, Maryland			A. STATE Maryland		
			B. COUNTY Baltimore		
			C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER 271 Oaklee Village		
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH		9. AGE (In years last birthday)
Female	White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	7-1-1893		76
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Housewife				Maryland	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
George O. Evans			Mary E. O'Dell		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT	
No				Mr. Lee E. Thomas, 271 Oaklee Village 21229	
18. <span style="font-size: 1.5em;">250.9 I</span> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)			CAUSE OF DEATH		
ANTECEDENT CAUSES  DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  <span style="font-size: 1.5em;">10 years</span>  <span style="font-size: 1.5em;">15 years</span>
			(B) <span style="font-size: 1.5em;">H.C.U.D.</span> DUE TO, OR AS A CONSEQUENCE OF:		
			(C) _____		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <span style="font-size: 1.5em;">Jan 15, 1969</span> to <span style="font-size: 1.5em;">12/17/1969</span> that (I) (we) last saw the deceased alive on <span style="font-size: 1.5em;">12/17 1969</span> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <span style="font-size: 1.5em;">Paul Schonfeld</span>				23B. DATE SIGNED <span style="font-size: 1.5em;">12/18/69</span>	
23C. PHYSICIAN'S NAME (Type) Dr. Paul Schonfeld				23D. ADDRESS 2301 Annapolis Road, Baltimore, Md.	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
Burial		12-20-69		Woodlawn Cemetery	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
<span style="font-size: 1.5em;">DEC 22 1969</span>		<span style="font-size: 1.5em;">Robert E. Taylor</span>		Howard H. Hubbard, 4107 Wilkens Ave. 21229	

10/1/01  
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at the North

P. V. 9.4

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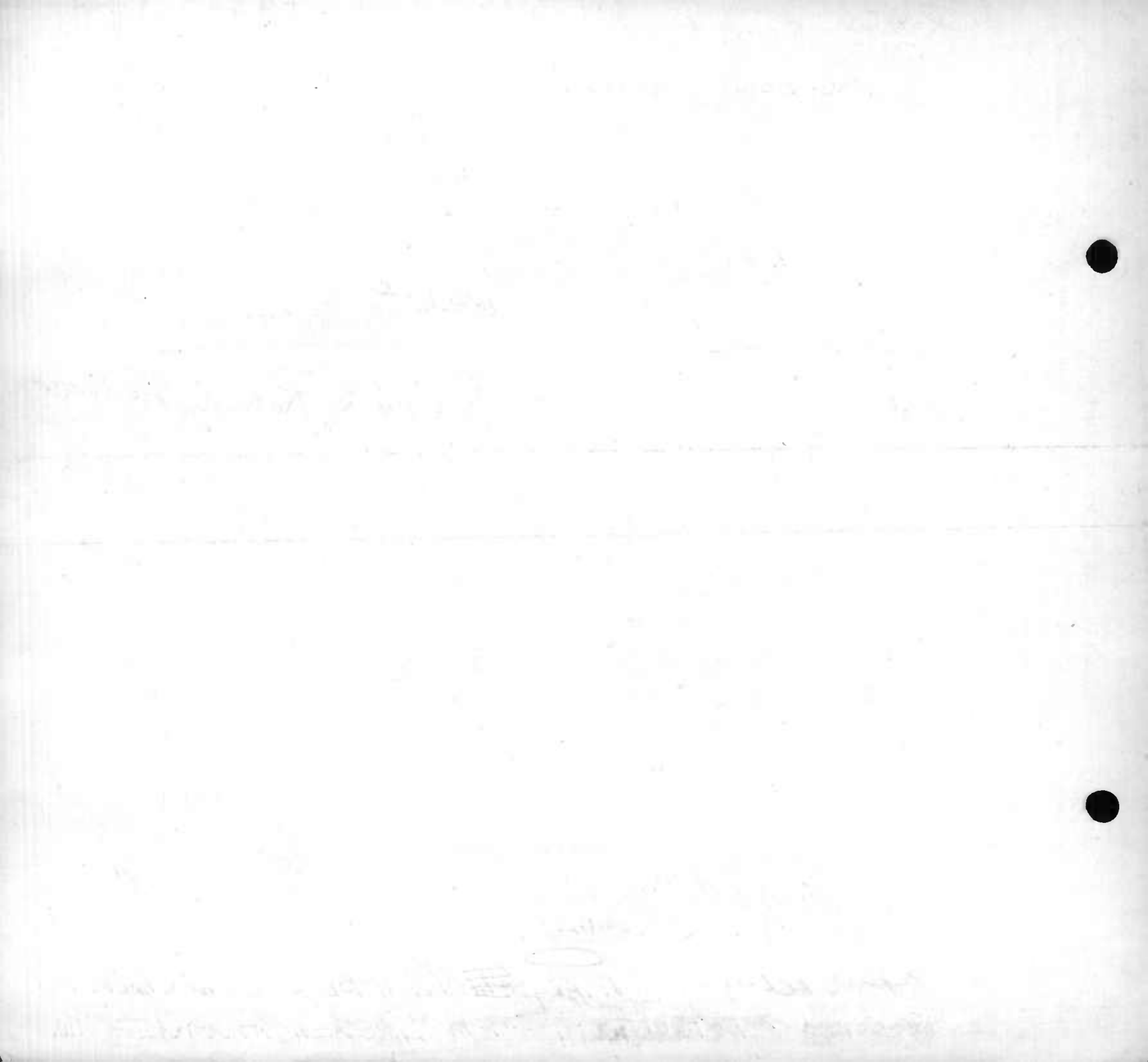
at the North



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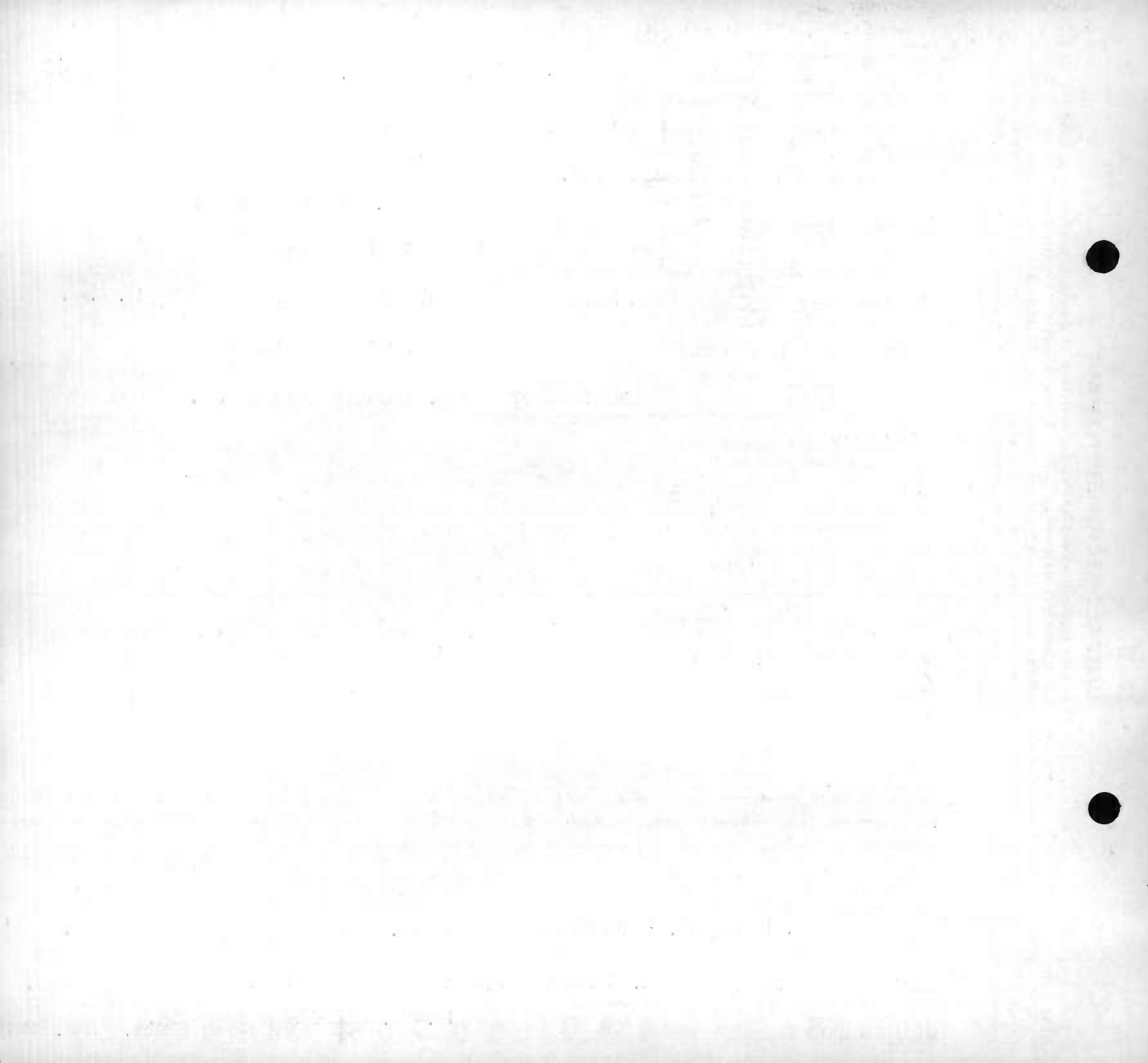
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="font-size: 1.2em;">69 12598</span>	
<b>R-152</b> <b>69 12598</b> <b>CERTIFICATE OF DEATH</b>		<b>1. NAME OF DECEASED</b> (Type or Print) <span style="font-size: 1.2em;">Robinson Charles</span>			
<b>2. DATE AND HOUR OF DEATH</b> <span style="font-size: 1.2em;">12/11/69 11:45 AM</span>		<b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b> FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <span style="font-size: 1.2em;">90 Harbor View D.C.C. 1213 Light St.</span>			
<b>4. USUAL RESIDENCE</b> (Where deceased lived. If institution: residence before admission) A. STATE <span style="font-size: 1.2em;">Md.</span> B. COUNTY <span style="font-size: 1.2em;">#15 2841</span>		<b>5. CITY OR TOWN</b> <span style="font-size: 1.2em;">Bkto.</span>			
<b>6. INSIDE CITY LIMITS?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		<b>7. STREET AND NUMBER</b> <span style="font-size: 1.2em;">3911 Grouland Ave</span>			
<b>8. SEX</b> <span style="font-size: 1.2em;">m.</span>	<b>9. RACE</b> <span style="font-size: 1.2em;">Col.</span>	<b>10. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	<b>11. DATE OF BIRTH</b> <span style="font-size: 1.2em;">1883</span>	<b>12. AGE</b> (In years last birthday) <span style="font-size: 1.2em;">85</span>	<b>13. CITIZEN OF WHAT COUNTRY?</b> <span style="font-size: 1.2em;">USA</span>
<b>14A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">Retired</span>		<b>14B. KIND OF BUSINESS OR INDUSTRY</b> <span style="font-size: 1.2em;">Retired</span>		<b>14C. BIRTHPLACE</b> (State or foreign country) <span style="font-size: 1.2em;">WASH. D.C.</span>	
<b>15. FATHER'S NAME</b> <span style="font-size: 1.2em;">?</span>		<b>16. MOTHER'S MAIDEN NAME</b> <span style="font-size: 1.2em;">?</span>		<b>17. INFORMANT</b> <span style="font-size: 1.2em;">Joseph S. Robinson</span>	
<b>18. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service) <span style="font-size: 1.2em;">No</span>		<b>19. SOCIAL SECURITY NO.</b> <span style="font-size: 1.2em;">213-22-0136</span>		<b>20. ADDRESS</b> <span style="font-size: 1.2em;">Ridgelyville, Md.</span>	
<b>21. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>22. ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		<b>23. CAUSE OF DEATH</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <span style="font-size: 1.2em;">Cardiac Arrest C.V.A.</span> (B) <span style="font-size: 1.2em;">Arteriosclerosis Cardio-Vascular Disease</span> DUE TO, OR AS A CONSEQUENCE OF: <span style="font-size: 1.2em;">Disease</span> (C) _____		<b>24. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</b> <span style="font-size: 1.2em;">Sudden Feb 1969 ?</span>	
<b>25. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</b>					
<b>26. DATE OF OPERATION</b> <span style="font-size: 1.2em;">0</span>		<b>27. CONDITION FOR WHICH OPERATION WAS PERFORMED</b>		<b>28. AUTOPSY?</b> (Yes or No) <span style="font-size: 1.2em;">No</span>	
<b>29. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner) <input type="checkbox"/>		<b>30. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		<b>31. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)	
<b>32. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (APPROX.)		<b>33. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		<b>34. HOW DID INJURY OCCUR?</b>	
<b>35. I certify that (I) (this hospital) attended the deceased from <span style="font-size: 1.2em;">4/2/69</span> 19 to <span style="font-size: 1.2em;">12/11</span> 19 <span style="font-size: 1.2em;">69</span>, that (I) (we) last saw the deceased alive on _____ 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</b>					
<b>36. SIGNATURE</b> <span style="font-size: 1.2em;">Joseph S. Blum</span>		<b>37. DEGREE</b> <span style="font-size: 1.2em;">M.D.</span>		<b>38. DATE SIGNED</b> <span style="font-size: 1.2em;">12/11/69</span>	
<b>39. PHYSICIAN'S NAME</b> (Type) <span style="font-size: 1.2em;">JOSEPH S. BLUM</span>		<b>40. ADDRESS</b> <span style="font-size: 1.2em;">MD</span>			
<b>41. BURIAL CREMATION, REMOVAL</b> (Specify) <span style="font-size: 1.2em;">12-16-69</span>		<b>42. DATE</b> <span style="font-size: 1.2em;">12-16-69</span>		<b>43. NAME OF CEMETERY OR CREMATORY</b> <span style="font-size: 1.2em;">St. Mary's Church</span>	
<b>44. LOCATION</b> (City, town, or county) (State) <span style="font-size: 1.2em;">Bryan Town Charles Md.</span>		<b>45. FUNERAL DIRECTOR</b> <span style="font-size: 1.2em;">H. E. Moran</span>			
<b>46. DATE REC'D BY HEALTH DEPT.</b> <span style="font-size: 1.2em;">DEC 22 1969</span>		<b>47. NAME OF REGISTRAR</b> <span style="font-size: 1.2em;">J. E. Moran</span>		<b>48. ADDRESS</b> <span style="font-size: 1.2em;">H. E. Moran</span>	



FUNERAL DIRECTOR: IMPORTANT

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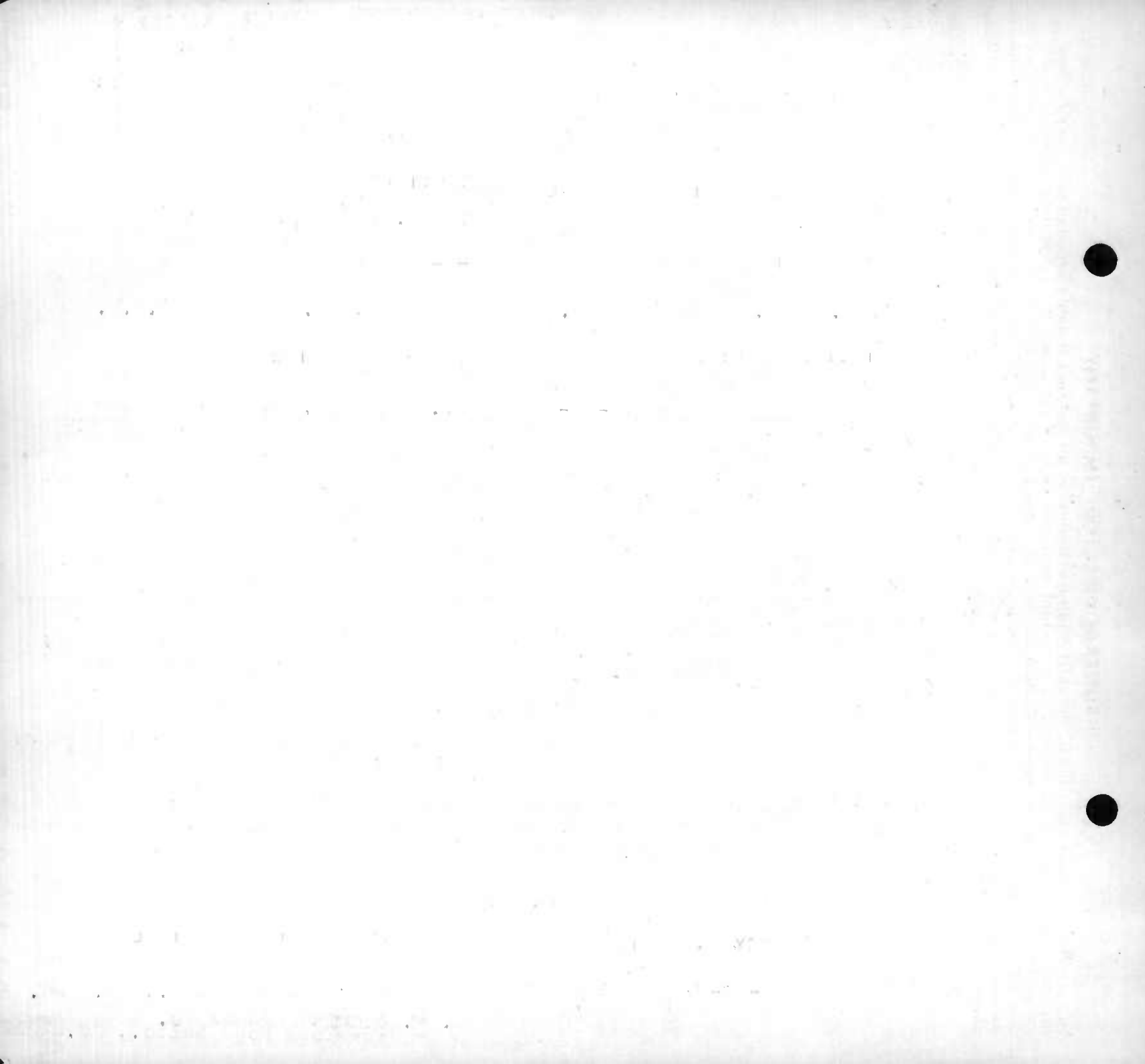
B-635				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 69 12599	
69 12599				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Isabel Rieman Thom Barton				2. DATE AND HOUR OF DEATH Dec. 18, 1969			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Apt 3D The Warrington Apts.				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 3908 N. Charles Street			
5. SEX F	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-20-1891		9. AGE (In years last birthday) 77	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10B. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Pembroke Lee Thom				14. MOTHER'S MAIDEN NAME Mary Isabel Rieman			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 220-14-7437		17. INFORMANT Mr. Carlyle Barton, Jr.		ADDRESS Same	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH (A) <u>2 mo</u> (B) <u>6 mo</u> (C) <u>20 yrs</u>			
19A. DATE OF OPERATION 0				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>Sept 2</u> 19 <u>69</u> to <u>Dec 18</u> 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>Dec 18</u> 19 <u>69</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>H. F. Klinefelter</u>				23B. DATE SIGNED <u>12/19/69</u>		23C. PHYSICIAN'S NAME (Type) Dr. Harry F. Klinefelter	
23D. ADDRESS 550 N. Broadway				23E. FUNERAL DIRECTOR H. W. Jenkins & Sons Co. ADDRESS 495 York Road Balto., Md. 21211			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12-20-69		24C. NAME OF CEMETERY OR CREMATORY St. Thomas' Cemetery		24D. LOCATION (City, town, or county) Garrison Forest, (State) Md.	
25A. DATE REC'D BY HEALTH DEPT. DEC 22 1969		25B. NAME OF REGISTRAR <u>Robert E. Taylor</u>		25C. FUNERAL DIRECTOR H. W. Jenkins & Sons Co. ADDRESS 495 York Road Balto., Md. 21211			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

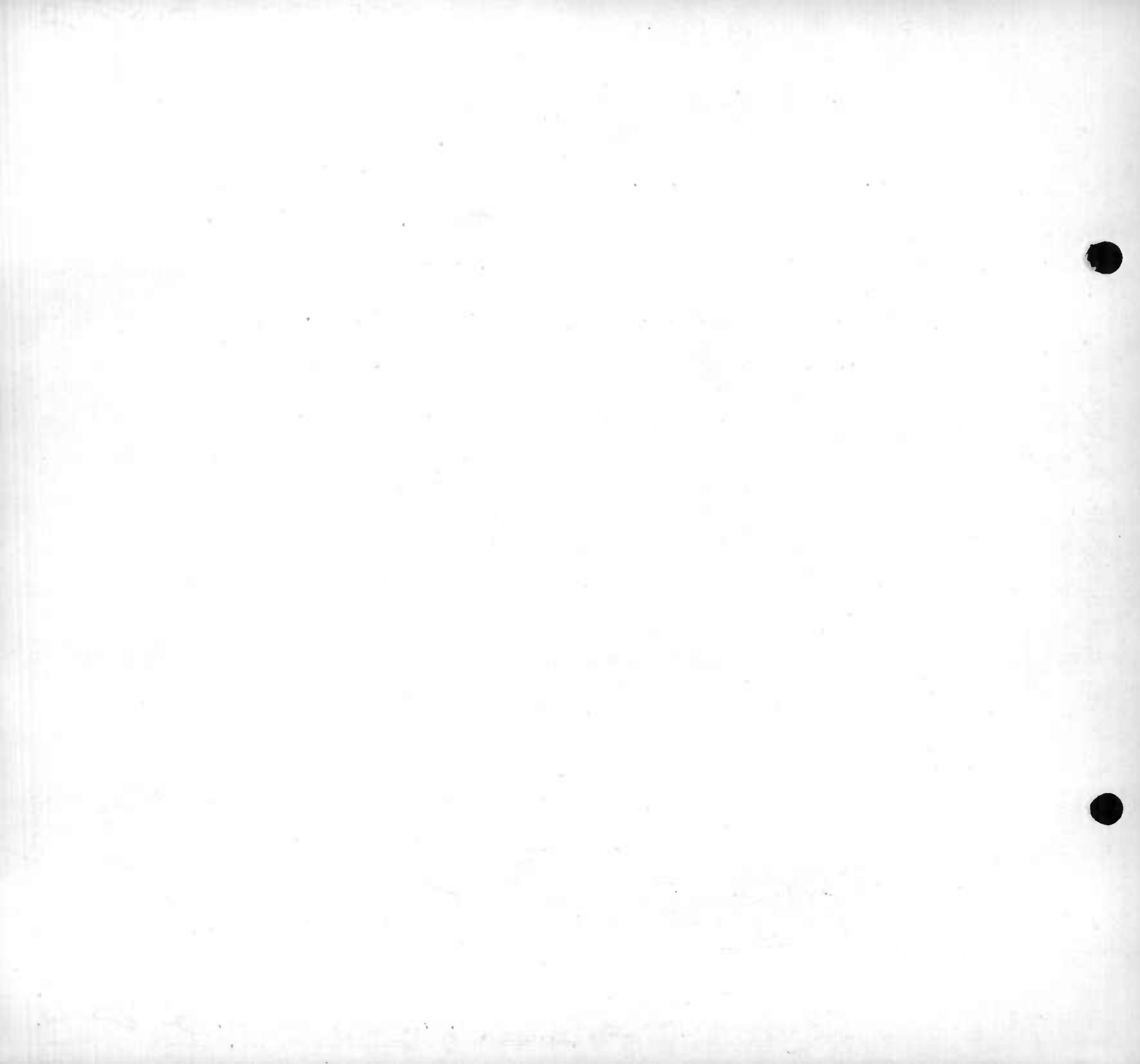
BALTIMORE CITY HEALTH DEPARTMENT REG. NO. 06 03 9169 12600			
P-625 BIRTH NO. 68 12600		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <b>WALTER F. PERKINS</b>		2. DATE AND HOUR OF DEATH <b>12-19-69 5:45 PM</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTIMORE</b>	
FULL NAME OF HOSPITAL OR INSTITUTION <b>33 THE JOHNS HOPKINS HOSPITAL</b>		C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <b>100 W. COLDSRING LANE</b>			
5. SEX <b>MALE</b>	6. RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6-3-91</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Ret'd V. Pres.</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Koppers Co.</b>	9. AGE (In years last birthday) <b>78</b>
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>WILLIAM PERKINS</b>		14. MOTHER'S MAIDEN NAME <b>IDA FREDERICK</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>212-07-9833</b>	
17. INFORMANT <b>Mrs. Walter F. Perkins</b>		ADDRESS <b>Same</b>	
18. CAUSE OF DEATH			
<div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <p><b>I</b></p> <p>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</p> <p>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</p> <p><b>ANTECEDENT CAUSES</b></p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p> </div> <div style="width: 50%;"> <p>(A) IMMEDIATE CAUSE <i>Metastatic Ca prostate</i> DUE TO, OR AS A CONSEQUENCE OF:</p> <p>(B) _____ DUE TO, OR AS A CONSEQUENCE OF:</p> <p>(C) _____</p> </div> </div>			
<p style="text-align: center;"><b>II</b></p> <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</p>			
19A. DATE OF OPERATION <b>12/17/69</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) <b>NO</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>12/17/69</b> 19 <b>69</b> to <b>12/19</b> 19 <b>69</b> , that (I) (we) last saw the deceased alive on <b>12/19/69 4pm</b> 19 <b>69</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <i>Harvey G. Klein M.D.</i>		23B. DATE SIGNED <b>12/19/69</b>	
23C. PHYSICIAN'S NAME (Type) <b>HARVEY G. KLEIN</b>		23D. ADDRESS <b>THE JOHNS HOPKINS HOSPITAL</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>12-22-69</b>	24C. NAME OF CEMETERY or CREMATORY <b>Woodlawn Cemetery</b>	24D. LOCATION (City, town, or county) (State) <b>Woodlawn, Balto., Co. Md.</b>
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 22 1969</b>	25B. NAME OF REGISTRAR <i>Robert E. Fisher M.D.</i>	25C. FUNERAL DIRECTOR <b>H. W. Perkins &amp; Sons Co.</b> ADDRESS <b>4905 York Road Balto., Md. 21212</b>	



**FUNERAL DIRECTOR: IMPORTANT**

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BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.	69 12601
<b>BIRTH NO.</b> <b>1. NAME OF DECEASED</b> (Type or Print) <span style="float: right;">Maranda M. Bloberger</span>		<b>2. DATE AND HOUR OF DEATH</b> <div style="text-align: right;">12/19/69 <i>prob. 9 pm</i></div>			
<b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b>  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 1124 E. Belvedere Apt. B.		<b>4. USUAL RESIDENCE</b> (Where deceased lived. If institution, residence before admission) A. STATE <span style="float: right;">Md.</span> B. COUNTY <span style="float: right;">2748</span> <b>C. CITY OR TOWN</b> Baltimore <b>D. INSIDE CITY LIMITS?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> <b>E. STREET AND NUMBER</b> 1124 E. Belvedere Ave.			
<b>5. SEX</b> F	<b>6. RACE</b> W	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> 10-4-1891	<b>9. AGE</b> (In years last birthday) 78
<b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) Housewife		<b>10B. KIND OF BUSINESS OR INDUSTRY</b> Own Home		<b>11. BIRTHPLACE</b> (State or foreign country) Baltimore, Md.	
<b>12. CITIZEN OF WHAT COUNTRY?</b> USA		<b>13. FATHER'S NAME</b> James C. Pearce			
<b>14. MOTHER'S MAIDEN NAME</b> Marion L. Markley		<b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service) No			
<b>16. SOCIAL SECURITY NO.</b> 212-38-2599B		<b>17. INFORMANT</b> Mrs. Marion M. Imhoff			
<b>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		<b>CAUSE OF DEATH</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Antecoronary Heart M. (B) DUE TO, OR AS A CONSEQUENCE OF: (C)			
<b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
<b>19A. DATE OF OPERATION</b> 4/12/31		<b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b>		<b>20A. AUTOPSY?</b> (Yes or No) <input checked="" type="checkbox"/>	
<b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner) <input type="checkbox"/>		<b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg, etc.)		<b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)	
<b>21D. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (APPROX.)		<b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		<b>21F. HOW DID INJURY OCCUR?</b>	
<b>22. I certify that (1) (this hospital) attended the deceased from 1966 19 to 12/70 1969, that (1) (we) last saw the deceased alive on Sept 19 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.</b>					
<b>23A. SIGNATURE</b> <i>Sol Smith</i>		<b>23B. DATE SIGNED</b> 12/20/69		<b>23C. PHYSICIAN'S NAME</b> (Type) 1261 E Sol Smith	
<b>24A. BURIAL CREMATION, REMOVAL</b> (Specify) Burial		<b>24B. DATE</b> 12-23-69		<b>24C. NAME OF CEMETERY or CREMATORY</b> Parkwood Cemetery	
<b>24D. LOCATION</b> (City, town, or county) Parkville		<b>24E. STATE</b> Md.			
<b>25A. DATE REC'D BY HEALTH DEPT.</b> DEC 22 1969		<b>25B. NAME OF REGISTRAR</b> <i>Robert E. Jenkins</i>		<b>25C. FUNERAL DIRECTOR</b> H.W. Jenkins Sons Co. 4905 York Rd.	
<b>ADDRESS</b> Baltimore, Md. 21212					





FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.	69 12602
<b>BIRTH NO.</b> <b>1. NAME OF DECEASED</b> (Type or Print) <span style="font-size: 1.2em;">Alice E. Hunold</span>		<b>2. DATE AND HOUR OF DEATH</b> <span style="font-size: 1.2em;">12-19-69</span> <span style="float: right;">1240A M.</span>			
<b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b>  <b>FULL NAME OF HOSPITAL OR INSTITUTION</b> (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  <span style="font-size: 1.2em;">House in Pines (Belvedere)</span> <span style="font-size: 1.5em;">90</span>		<b>4. USUAL RESIDENCE</b> (Where deceased lived, If institution: residence before admission) A. STATE <span style="font-size: 1.2em;">Md.</span> B. COUNTY <span style="font-size: 1.5em;">2778</span> <b>C. CITY OR TOWN</b> <span style="font-size: 1.2em;">Baltimore</span> <b>D. INSIDE CITY LIMITS?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> <b>E. STREET AND NUMBER</b> <span style="font-size: 1.2em;">823 Evesham Ave.</span>			
<b>5. SEX</b> <span style="font-size: 1.2em;">F</span>	<b>6. RACE</b> <span style="font-size: 1.2em;">W</span>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <span style="font-size: 1.2em;">12-29-1888</span>	<b>9. AGE</b> (In years last birthday) <span style="font-size: 1.2em;">80</span>	<b>If Under 1 Yr.</b> Months: Days: <b>If Under 24 Hrs.</b> Hours: Min.
<b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">Homemaker</span>		<b>10B. KIND OF BUSINESS OR INDUSTRY</b> <span style="font-size: 1.2em;">Own Home</span>		<b>11. BIRTHPLACE</b> (State or foreign country) <span style="font-size: 1.2em;">Maryland</span>	
<b>12. CITIZEN OF WHAT COUNTRY?</b> <span style="font-size: 1.2em;">USA</span>		<b>13. FATHER'S NAME</b> <span style="font-size: 1.2em;">Thomas Bull</span>			
<b>14. MOTHER'S MAIDEN NAME</b> <span style="font-size: 1.2em;">Mary E. Harper</span>		<b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service) <span style="font-size: 1.2em;">No</span>			
<b>16. SOCIAL SECURITY NO.</b> <span style="font-size: 1.2em;">217-01-4569</span>		<b>17. INFORMANT</b> <span style="font-size: 1.2em;">Mrs. J. Graham Hartzell</span> <b>ADDRESS</b> <span style="font-size: 1.2em;">823 Evesham Ave</span>			
<b>18. CAUSE OF DEATH</b> <div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <b>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b>                      (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)   <b>ANTECEDENT CAUSES</b>                      DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.                 </div> <div style="width: 50%;"> <b>(A) IMMEDIATE CAUSE</b> <span style="font-size: 1.2em;">Acute Myocardial Infarction</span>                      DUE TO, OR AS A CONSEQUENCE OF:  <span style="font-size: 1.2em;">arteriosclerosis CVD</span>   <b>(B) IMMEDIATE CAUSE</b> <span style="font-size: 1.2em;">Impending Myocardial Failure</span>                      DUE TO, OR AS A CONSEQUENCE OF:  <span style="font-size: 1.2em;">+ infarction due to CVD</span>   <b>(C)</b> </div> <div style="width: 45%;"> <b>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</b>  <span style="font-size: 1.2em;">10 yr.</span>   <span style="font-size: 1.2em;">1. yr.</span> </div> </div>					
<b>II</b> <b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</b>					
<b>19A. DATE OF OPERATION</b> <span style="font-size: 1.2em;">0</span>		<b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b>		<b>20A. AUTOPSY?</b> (Yes or No) <span style="font-size: 1.2em;">No</span>	
<b>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</b>		<b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner) <input type="checkbox"/>			
<b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		<b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)			
<b>21D. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (APPROX.)		<b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		<b>21F. HOW DID INJURY OCCUR?</b>	
<b>22. I certify that (I) (this hospital) attended the deceased from</b> <span style="font-size: 1.2em;">Oct 23 1969</span> <b>to</b> <span style="font-size: 1.2em;">Dec 19 1969</span> <b>that (I) (we) last saw the deceased alive on</b> <span style="font-size: 1.2em;">Dec 18 1969</span> <b>and that in (my) (our) opinion death occurred on the date</b> <b>and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.</b>					
<b>23A. SIGNATURE</b> <span style="font-size: 1.2em;">Lester Coleman</span> <span style="float: right;">Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/></span>				<b>23B. DATE SIGNED</b> <span style="font-size: 1.2em;">12/19/69</span>	
<b>23C. PHYSICIAN'S NAME</b> (Type) <span style="font-size: 1.2em;">Dr. Lester Coleman</span>				<b>23D. ADDRESS</b> <span style="font-size: 1.2em;">6821 Reisterstown Rd. 21215</span>	
<b>24A. BURIAL CREMATION, REMOVAL</b> (Specify) <span style="font-size: 1.2em;">Burial</span>		<b>24B. DATE</b> <span style="font-size: 1.2em;">12-22-69</span>		<b>24C. NAME OF CEMETERY OR CREMATORY</b> <span style="font-size: 1.2em;">Parkwood Cemetery</span>	
<b>24D. LOCATION</b> (City, town, or county) (State) <span style="font-size: 1.2em;">Parkville Md.</span>		<b>25A. DATE REC'D BY HEALTH DEPT.</b> <span style="font-size: 1.2em;">DEC 22 1969</span> <b>25B. NAME OF REGISTRAR</b> <span style="font-size: 1.2em;">Robert E. Talley, Md.</span>			
<b>25C. FUNERAL DIRECTOR</b> <span style="font-size: 1.2em;">D. W. Jenkins &amp; Sons Co.</span> <b>ADDRESS</b> <span style="font-size: 1.2em;">4905 York Rd. Baltimore, Md. 21212</span>					



# FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT										
69 12603					69 12603					
BIRTH NO.					REG. NO.					
1. NAME OF DECEASED (Type or Print) <i>Arthur J. Grove</i>					2. DATE AND HOUR OF DEATH <i>19 Dec 69</i>   <i>1:25 P</i> M.					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Md.</i> B. COUNTY <i>901</i>					
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>The Union Memorial Hospital</i>					C. CITY OR TOWN <i>Baltimore 21218</i>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			
					E. STREET AND NUMBER <i>821 Dunbarton Ave.</i>					
5. SEX <i>M</i>	6. RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <i>04-20-17</i>	9. AGE (In years last birthday) <i>52</i>	If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>RETIRED</i>			10B. KIND OF BUSINESS OR INDUSTRY <i>BENDIX CORP.</i>		11. BIRTHPLACE (State or foreign country) <i>Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>American U.S.A.</i>			
13. FATHER'S NAME <i>George Grove</i>					14. MOTHER'S MAIDEN NAME <i>Minnie Elsie PRICE</i>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>			16. SOCIAL SECURITY NO. <i>217-05-6790</i>		17. INFORMANT <i>Hospital Chart</i>			ADDRESS <i>CALVIN F. GROVE 801 DUNBARTON RD.</i>		
18. <i>320.9</i> I CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <i>Bacterial meningitis</i>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:  (B) DUE TO, OR AS A CONSEQUENCE OF:  (C) DUE TO, OR AS A CONSEQUENCE OF:					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <i>Perforation of duodenal ulcer and posterior perforation</i>										
19A. DATE OF OPERATION <i>2</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No) <i>Yes</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>Yes</i>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?					
22. I certify that (1) (this hospital) attended the deceased from <i>11-20</i> 19 <i>69</i> to <i>12-19</i> 19 <i>69</i> , that (1) (we) last saw the deceased alive on <i>12-19</i> 19 <i>69</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.										
23A. SIGNATURE <i>M. Copeda M.D.</i>					Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>			23B. DATE SIGNED <i>19 Dec 69</i>		
23C. PHYSICIAN'S NAME (Type) <i>Dr. M. Copeda</i>					23D. ADDRESS <i>Union Memorial Hosp.</i>					
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>12/22/69</i>		24C. NAME OF CEMETERY or CREMATORY <i>Moreland Mem. Park</i>		24D. LOCATION (City, town, or county) (State) <i>Balto. Co., Md.</i>				
25A. DATE REC'D BY HEALTH DEPT. <i>DEC 22 1969</i>			25B. NAME OF REGISTRAR <i>Robert E. Baker, 82.9</i>			25C. FUNERAL DIRECTOR <i>H. W. Jenkins &amp; Sons Co.</i>			ADDRESS <i>4905 York Rd. Balto., Md. 21212</i>	

George T. Brown

The Union Memorial Hospital  
Baltimore  
201 Good Hope Ave

M W 204-22-12 22

MB

George Brown  
Union Memorial Hospital  
Baltimore

to

12:10 PM 11:20 PM

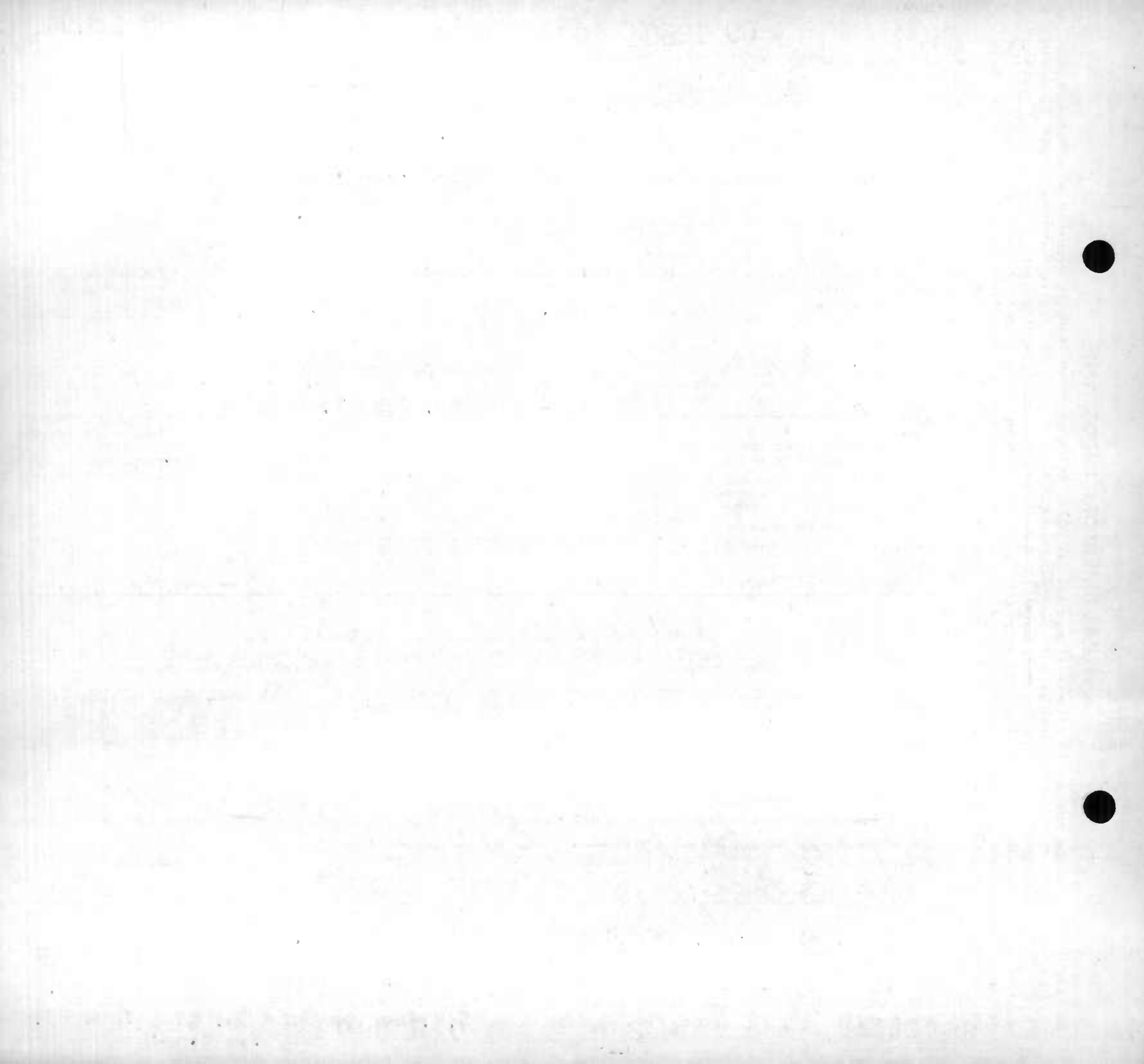
Class Memorial Day

Teachers

FUNERAL DIRECTOR: IMPORTANT

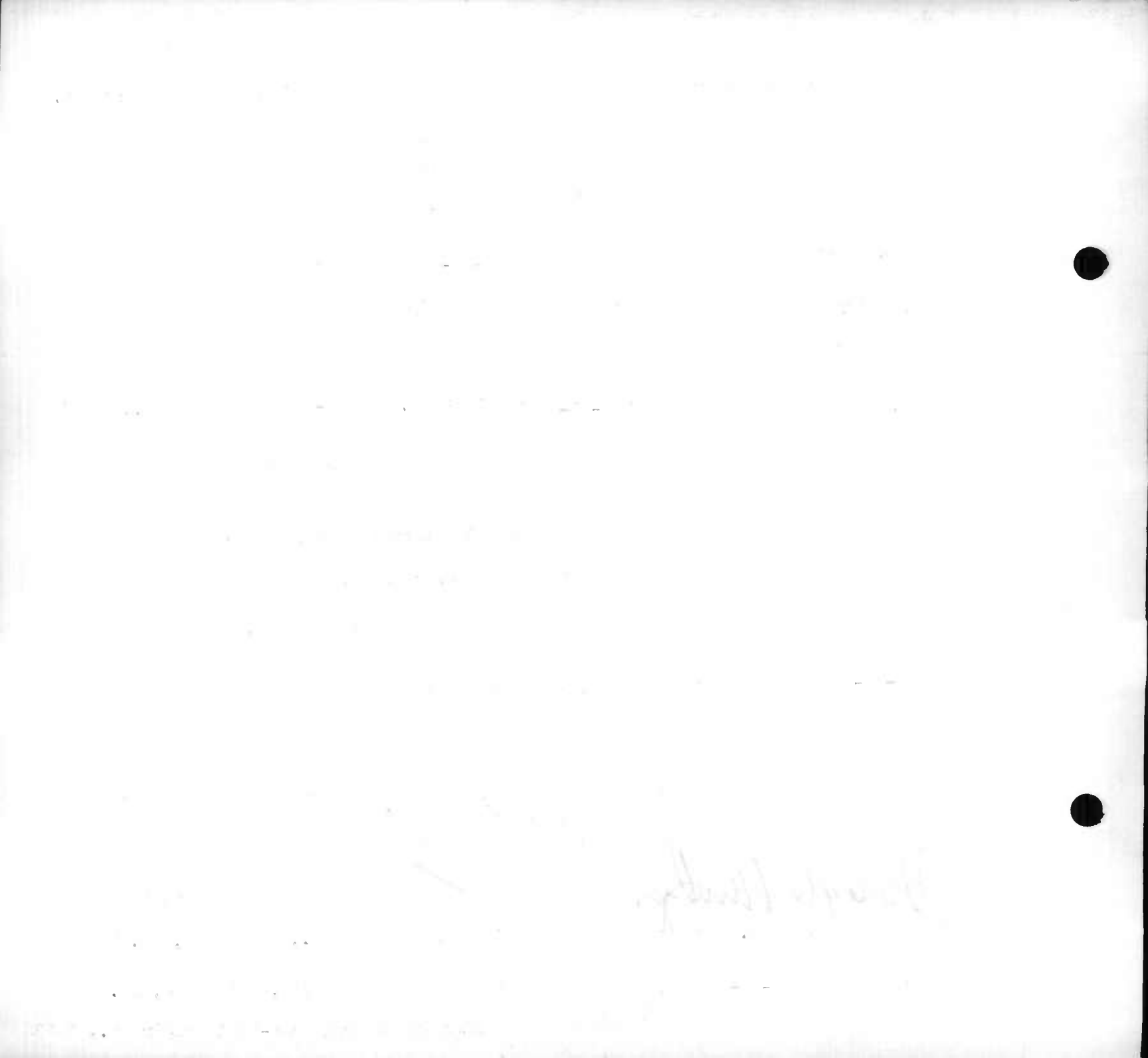
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.	69 12604
<b>M-256</b> <b>69 12604</b> <b>CERTIFICATE OF DEATH</b>					
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
Ann Daly McKannar		12-22-69		3 <sup>00</sup> A M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE B. COUNTY			
Edgewood Nursing Home		Md.			
		C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
		Balto., Md.		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER			
		328 Taplow Rd.			
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months: Days: II Under 24 Hrs. Hours: Min.
F	W	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	11-8-1883	86	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Supervisor		Md. State Emp.		Baltimore, Md.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
John D. McKannar		Ann Daly		USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No		212-07-3082		Mr. John T. Bossert Same	
18. CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
I 440.9 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Arteriosclerosis</i> (B) DUE TO, OR AS A CONSEQUENCE OF: (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
0				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>1961</i> to <i>Dec 21 1969</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE		23B. DATE SIGNED			
<i>Dr. William G. Helfrich</i>		12-22-69			
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
Dr. William G. Helfrich		5006 Roland Ave.			
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial	12-24-69	New Cathedral Cemetery		Baltimore Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
DEC 22 1969		Robert E. Jenkins		H. W. Jenkins Sons Co. 4905 York Rd. Balto., Md. 21212	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

VS 150-REV. 1/1/68





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Bodily burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 69 12606	
<div style="display: flex; justify-content: space-between;"> <span>D-140</span> <span>69 12606</span> <span>CERTIFICATE OF DEATH</span> </div>					
BIRTH NO.					
1. NAME OF DECEASED (Type or Print) <b>FLORENCE ALICE DUVAL</b>			2. DATE AND HOUR OF DEATH <b>Dec 18-1969 7:00 PM</b> M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>1202</b>		
FULL NAME OF HOSPITAL OR INSTITUTION <b>44 UNION MEM. HOSP</b>			C. CITY OR TOWN <b>BALTO</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			E. STREET AND NUMBER <b>3401 Greenway</b>		
5. SEX <b>Female</b>	6. RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8-13-95</b>	9. AGE (In years lost birthday) <b>74 (74)</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, <del>even</del> if retired) <b>NONE</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>NONE KNOWN</b>		11. BIRTHPLACE (State or foreign country) <b>Cumberland Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA AMERICAN</b>			13. FATHER'S NAME <b>DUKE DORNEY</b>		
14. MOTHER'S MAIDEN NAME <b>FLORENCE PALATT (PALLATT)</b>			15. Was Deceased Ever in U. S. Armed Forces? (Yes/no or unknown) (If yes, give war or dates of service) <b>NO</b>		
16. SOCIAL SECURITY NO. <b>213-15-0330B</b>		17. INFORMANT ADDRESS <b>ERNEST M. DUVAL -3401 Greenway -21218</b>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>562.11</b>			CAUSE OF DEATH <b>BRONCHO PNEUMONIA</b>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Broncho pneumonia Nov. 21, 1969</b>		
(B) DUE TO, OR AS A CONSEQUENCE OF: <b>Abscess of Rt lung Dec. 18, 69</b>			(C) <b>pulmonary infarction</b>		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>3-11-55</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Obst. sigmoid</b>		20A. AUTOPSY? (Yes or No) <b>NO</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <b>NO</b>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>11-21-</b> 19 <b>69</b> to <b>12-18</b> 19 <b>69</b> , that (I) (we) last saw the deceased alive on <b>Dec. 18</b> 19 <b>69</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Benvenuto B. Capati M.D.</b>				23B. DATE SIGNED <b>Dec 18-69</b>	
23C. PHYSICIAN'S NAME (Type) <b>Benvenuto B. CAPATI M.D.</b>				23D. ADDRESS <b>Union Mem. Hosp.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>12/22/69</b>		24C. NAME OF CEMETERY or CREMATORY <b>Green Mount Mausoleum</b>	
24D. LOCATION <b>Baltimore, Maryland</b>		24E. LOCATION (City, town, or county) (State)			
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 23 1969</b>		25B. NAME OF REGISTRAR <b>Robert E. Fisher M.D.</b>		25C. FUNERAL DIRECTOR ADDRESS <b>STEWART &amp; MOWEN CO. 108 W. North Av., Cityl</b>	

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="font-size: 1.2em;">69 12607</span>	
H-325		69 12607		CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>Mrs. Elizabeth R. Hutson</b>		2. DATE AND HOUR OF DEATH <b>12/20/69 2:00 P. M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION <b>91 Keswick Home</b> (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>1201</b> C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>7000 W. 40th Street Lombardy Apartments</b>			
5. SEX <b>F.</b>	6. RACE <b>W.</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>10/4/1879</b>	9. AGE (in years lost birthday) <b>90</b>	If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Payroll Clerk</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>U.S. Government</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Ira Chevers Canfield</b>		14. MOTHER'S MAIDEN NAME <b>Marguerite Duff</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>DOUBTFUL</b>		16. SOCIAL SECURITY NO. <b>220-44-4143</b>		17. INFORMANT <b>RECORDS: KESWICK</b> <b>Mrs. Frederick, R.N.</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>485-X1</b> <b>BRONCHOPNEUMONIA</b>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>BRONCHOPNEUMONIA</b> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>6 days</b>	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>Senility, secondary to arteriosclerosis</b>			
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <del>the</del> (this hospital) attended the deceased from <b>Dec. 27</b> 19 <b>68</b> to <b>Dec.</b> 19 <b>69</b> , that <del>the</del> (we) last saw the deceased alive on <b>Dec. 20</b> 19 <b>69</b> and that in <del>the</del> (our) opinion death occurred on the date and hour and from the causes stated above. <del>the</del> (We) (did) <del>not</del> view the body after death.					
23A. SIGNATURE <b>W.D. Daniels, Jr. M.D.</b>		23B. DATE SIGNED <b>12/22/69</b>		23C. PHYSICIAN'S NAME (Type) <b>Dr. Worth Daniels, Jr.</b>	
23D. ADDRESS <b>220 Ridgewood Rd. Keswick, Baltimore Md.</b>		23E. DATE <b>12/22/69</b>		23F. SIGNATURE <b>W.D. Daniels, Jr. M.D.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>Dec. 23, 69</b>		24C. NAME OF CEMETERY or CREMATORY <b>Green Mount Cemetery</b>	
24D. LOCATION <b>Baltimore, Maryland</b>		24E. DATE REC'D BY HEALTH DEPT. <b>DEC 23 1969</b>		24F. NAME OF REGISTRAR <b>Robert E. Taylor, M.D.</b>	
24G. FUNERAL DIRECTOR <b>STEWART &amp; MORRIS</b>		24H. ADDRESS <b>CO. 108 W. North Av. City 1</b>		24I. SIGNATURE <b>STEWART &amp; MORRIS</b>	

270 Stoney Run La.

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

C-220		69 12608		BALTIMORE CITY HEALTH DEPARTMENT		X Registered No. 69 12608	
BIRTH NO.				M.E. CASE NO.			
1. NAME OF DECEASED (Type or Print)				FRANK CISZEWSKI		2. DATE AND HOUR OF DEATH 12-21-69 7:30 a.m.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION		(If not in hospital or institution, give street address or location)		A. STATE MD.		B. COUNTY BALTIMORE	
48 MARYLAND GENERAL HOSPITAL				C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE - RURAL - BROOKLYN		5200	
D. STREET ADDRESS (If rural, give location) 518 HAMMONDS LA.							
5. SEX M	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 9-25-88	9. AGE (In years last birthday) 81	If Under 1 Yr. Months: Days:		If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED		10B. KIND OF BUSINESS OR INDUSTRY COAST GUARD		11. BIRTHPLACE (State or foreign country) POLAND		12. CITIZEN OF WHAT COUNTRY? POLAND	
13. FATHER'S NAME JOHN CISZEWSKI				14. MOTHER'S MAIDEN NAME MARY KLAMENT			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 207-03-0893		17. INFORMANT ADDRESS HELEN CISZEWSKI - 518 HAMMONDS LANE			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) DUE TO CARCINOMA OF PANCREAS (B) DUE TO BILIARY OBSTRUCTION & ASCITES (C) HYPERTENSION, ESSENT.		INTERVAL BETWEEN ONSET AND DEATH OVER 15 MTHS. 9 MTHS. 10 YRS.	
MEDICAL CERTIFICATION							
19A. DATE OF OPERATION OCT '68		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED CA. PANCREAS		20A. AUTOPSY? (Yes or No) No.		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (H) (this hospital) attended the deceased from 11-15-69 to 12-21-69, that (I) (we) lost saw the deceased alive on 11-21-69, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE J.H. MATHER				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 12-21-69	
23C. PHYSICIAN'S NAME (Type) J.H. MATHER				23D. ADDRESS 5308-D. LEITH RD. BALT. MD 21201			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/24/69		24C. NAME of CEMETERY or CREMATORY Holy Cross Cemetery - BROOKLYN		24D. LOCATION (City, town, or county) (State) Baltimore, Brooklyn Md. A.A. Co	
25A. DATE REC'D BY HEALTH DEPT. DEC 23 1969		25B. NAME OF REGISTRAR Robert E. Zuber, M.D.		25C. FUNERAL DIRECTOR ADDRESS George A. Weber 705 South Ann Street			

FRANK GREENWALD

18 11 81

7-30

1812

M WHITE

MARRIED

18 11 81

CAPT. GREENWALD

18 11 81

JOHN GREENWALD

MARRIED

18 11 81

JOHN GREENWALD

69 12609

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 69 12609

BIRTH NO.

1. NAME OF DECEASED (Type and Print) <b>SARAH HOLLINS CLAIBORNE</b> <b>SARA CLAIBORNE</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> Month Day Year	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>44 Union Memorial Hospital</b> (If not in hospital or institution, give street address or location)		3. DATE PRONOUNCED DEAD Month Day Year <b>Dec. 18, 1969</b> 3:09 p.m.	
6. SEX <b>Female</b>		7. RACE <b>Negro</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>802</b>	
9. DATE OF BIRTH <b>5/17/24</b>		10. AGE (In years last birthday) <b>45</b> If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>NOAH BELL</b>		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
15. MOTHER'S MAIDEN NAME <b>GOLDIE WESLEY</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	
17. SOCIAL SECURITY NO.		18. INFORMANT ADDRESS <b>CLARENCE BELL 1915 W. Mulberry St.</b>	
19. <b>5-71.8</b> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>(A) IMMEDIATE CAUSE Fatty Liver</b> DUE TO, OR AS A CONSEQUENCE OF: <b>(B)</b> DUE TO, OR AS A CONSEQUENCE OF: <b>(C)</b> II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			
20A. DATE OF OPERATION <b>2</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) <b>YES</b>			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <b>Isidore Mihalakis, M.D.</b> CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <b>12/19/69</b> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12/23/69</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Mt. Auburn</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 23 1969</b>		25B. NAME OF REGISTRAR <b>Robert E. Fisher, M.D.</b>	
25C. FUNERAL DIRECTOR <b>Charles A. Rice</b>		25D. ADDRESS <b>661 W. Barre St.</b>	



Letter from M.E.'s office 4-16-70 M.H.



F-630

69 12610

BALTIMORE CITY HEALTH DEPARTMENT

69 12610

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>JOSEPHINE FORD</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>2214 Booth Street</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>December 20, 1969 3:25 P.</b>	
6. SEX <b>Female</b>		7. RACE <b>Negro</b>	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Baltimore</b>	
9. DATE OF BIRTH <b>5/10/01</b>		10. AGE (In years lost birthday) <b>68</b> If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) <b>South Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Reese Benjamin</b>		14. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>2004</b>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		14B. KIND OF BUSINESS OR INDUSTRY	
15. MOTHER'S MAIDEN NAME <b>Hager Benjamin</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>	
17. SOCIAL SECURITY NO. <b>219-16-4696</b>		18. INFORMANT ADDRESS <b>6 Talmadge Ford 2214 Booth St.</b>	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Hypertensive and Arteriosclerotic Cardiovascular Disease</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
(B) DUE TO, OR AS A CONSEQUENCE OF:		(C) DUE TO, OR AS A CONSEQUENCE OF:	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>Diabetes Mellitus</b>			
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) <b>no</b>			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE <b>Isidore Mihalakis, M.D.</b> M.D. EXAMINER'S NAME (Type) DATE SIGNED <b>12/21/69</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12/26/69</b>	
24C. NAME of CEMETERY or CREMATORY <b>Arbutus Mem. Park</b>		24D. LOCATION (City, town, or county) (State) <b>Arbutus, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 23 1969</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>	
25C. FUNERAL DIRECTOR <b>Charles A. Rice</b>		ADDRESS <b>661 W. Barre St.</b>	

ACADEMY BOND

PAID 10/10/10

BIRTH NO.				BALTIMORE CITY HEALTH DEPARTMENT				MEDICAL EXAMINER'S CERTIFICATE OF DEATH				REG. NO. 69 12611			
1. NAME OF DECEASED (Type or Print) <b>KENNETH COLVIN</b>				2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.				3. DATE PRONOUNCED DEAD Month Day Year Hour <b>Dec. 18, 1969 10:30p M.</b>				5. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>2101</b>			
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>University Hospital D.O.A</b>				6. SEX <b>Male</b>				7. RACE <b>Negro</b>				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
9. DATE OF BIRTH <b>11/17/69</b>				10. AGE (In years last birthday) <b>30</b>				11. BIRTHPLACE (State or foreign country) <b>Maryland</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Robert Colvin</b>				14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>				15. MOTHER'S MAIDEN NAME <b>Elizabeth Bailey</b>				16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)			
17. SOCIAL SECURITY NO. <b>219-26-9136</b>				18. INFORMANT <b>Robert Colvin</b>				19. CAUSE OF DEATH <b>304.9 I</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE <b>Intravenous narcotism</b> DUE TO, OR AS A CONSEQUENCE OF:											
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.				(B) DUE TO, OR AS A CONSEQUENCE OF:											
(C) DUE TO, OR AS A CONSEQUENCE OF:															
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).															
20A. DATE OF OPERATION <b>2</b>				20B. CONDITION FOR WHICH OPERATION WAS PERFORMED				21. AUTOPSY? (Yes or No) <b>YES</b>							
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?							
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				22F. HOW DID INJURY OCCUR?							
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>				ACTUAL EXAMINER'S NAME (Type) <b>Isidore Mihalakis, M.D.</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED <b>12/19/69</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>				24B. DATE <b>12/24/69</b>				24C. NAME OF CEMETERY or CREMATORY <b>Mt. Auburn</b>				24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 23 1969</b>				25B. NAME OF REGISTRAR <b>Robert E. Bailey, M.D.</b>				25C. FUNERAL DIRECTOR <b>Charles A. Rice</b>				ADDRESS <b>661 W. Barre St.</b>			

ACADEMIC PROMOTION

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.	69 12612	
E-524 69 12612				CERTIFICATE OF DEATH X		
1. NAME OF DECEASED (Type or Print) <b>JOHN R ENGLE</b>				2. DATE AND HOUR OF DEATH <b>12-18-69 12:25 a.m.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MD</b> B. COUNTY <b>Baltimore</b>		
FULL NAME OF HOSPITAL OR INSTITUTION <b>South Baltimore General H.</b>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <b>Glen Arm</b>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
E. STREET AND NUMBER <b>Box 664</b>		5. SEX <b>M</b> 6. RACE <b>W</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>5-1-16</b>
9. AGE (In years last birthday) <b>53</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Guard</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>MD</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>John Engle</b>		14. MOTHER'S MAIDEN NAME <b>Nellie Skidmore</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes WW 11</b>		16. SOCIAL SECURITY NO. <b>214-16-2328</b>		17. INFORMANT <b>Mrs Marguerite Engle</b>		
ADDRESS <b>Same</b>		18. <b>410.9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) <b>Myocardial Infarct</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		(B) DUE TO, OR AS A CONSEQUENCE OF:		
(C) DUE TO, OR AS A CONSEQUENCE OF:		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?		
22. I certify that (X) (this hospital) attended the deceased from <b>12-5-1969</b> to <b>12-18-1969</b> , that (Y) (we) lost saw the deceased alive on <b>12-18-1969</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.						
23A. SIGNATURE <b>Felix J. Martin</b>				23B. DATE SIGNED <b>12-18-69</b>		
23C. PHYSICIAN'S NAME (Type) <b>FELIX J. MARTIN</b>				23D. ADDRESS <b>South Baltimore General</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12/22/69</b>		24C. NAME OF CEMETERY or CREMATORY <b>Baltimore, National</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 23 1969</b>		25B. NAME OF REGISTRAR <b>Robert E. Fisher, M.D.</b>		25C. FUNERAL DIRECTOR <b>Leonard J. Buck Inc. Baltimore, Maryland</b>		

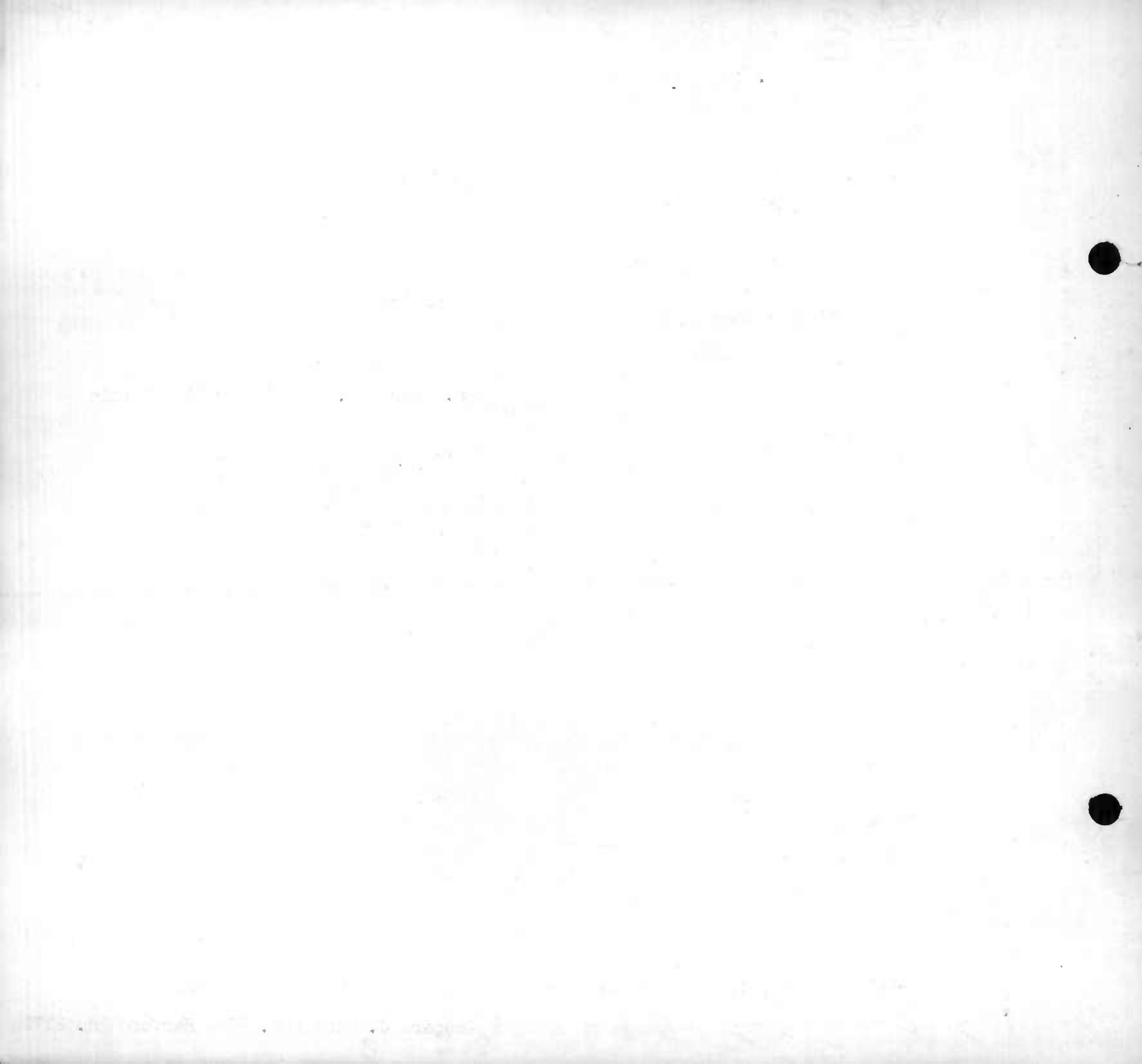




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <b>69 12613</b>	
BIRTH NO. <b>K-400</b>		69 12613	
1. NAME OF DECEASED (Type or Print) <b>ELLA R. KIEL</b>		2. DATE AND HOUR OF DEATH <b>12/18/69 11:50 AM</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>831</b>	
FULL NAME OF HOSPITAL OR INSTITUTION <b>HARBOR VIEW NCC</b>		C. CITY OR TOWN <b>Balto.</b>	D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
<b>1213 Light St #30</b>		E. STREET AND NUMBER <b>2932 CLIFTON PARK TERRACE</b>	
5. SEX <b>Female</b>	6. RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1884</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Homemaker</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	9. AGE (In years last birthday) <b>85</b>
13. FATHER'S NAME <b>LAWANCE NOLAN</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>216-09-4091</b>	17. INFORMANT <b>Mr. George J. Kiel 14 Dowling Circle</b>
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <b>412.4 I</b> (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Cardiac Standstill</b> <b>Ant. Sol. C-V Disease</b> <b>seriously</b> <b>Cer. Art. Sclerosis</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 hr</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>Urinary Tract Infection Dehydration</b>			
19A. DATE OF OPERATION <b>0</b>	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <b>12/13</b> 19 <b>69</b> to <b>12/18</b> 19 <b>69</b> , that (I) ( <del>we</del> ) last saw the deceased alive on <b>12/17</b> 19 <b>69</b> and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>We</del> ) ( <del>did</del> ) ( <del>did not</del> ) view the body after death.			
23A. SIGNATURE <b>Kenneth Krulvitz MD</b>			23B. DATE SIGNED <b>12/18/69</b>
23C. PHYSICIAN'S NAME (Type) <b>Kenneth Krulvitz MD</b>		23D. ADDRESS <b>115 W. Monument St. Balto Md</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>12/22/69</b>	24C. NAME OF CEMETERY or CREMATORY <b>New Cathedral Cemetery</b>	24D. LOCATION (City, town, or county) (State) <b>Baltimore Maryland</b>
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 23 1969</b>		25B. NAME OF REGISTRAR <b>Robert E. Talbot</b>	25C. FUNERAL DIRECTOR <b>Leonard J. Ruck Inc. 5305 Harford Rd. 21214</b>

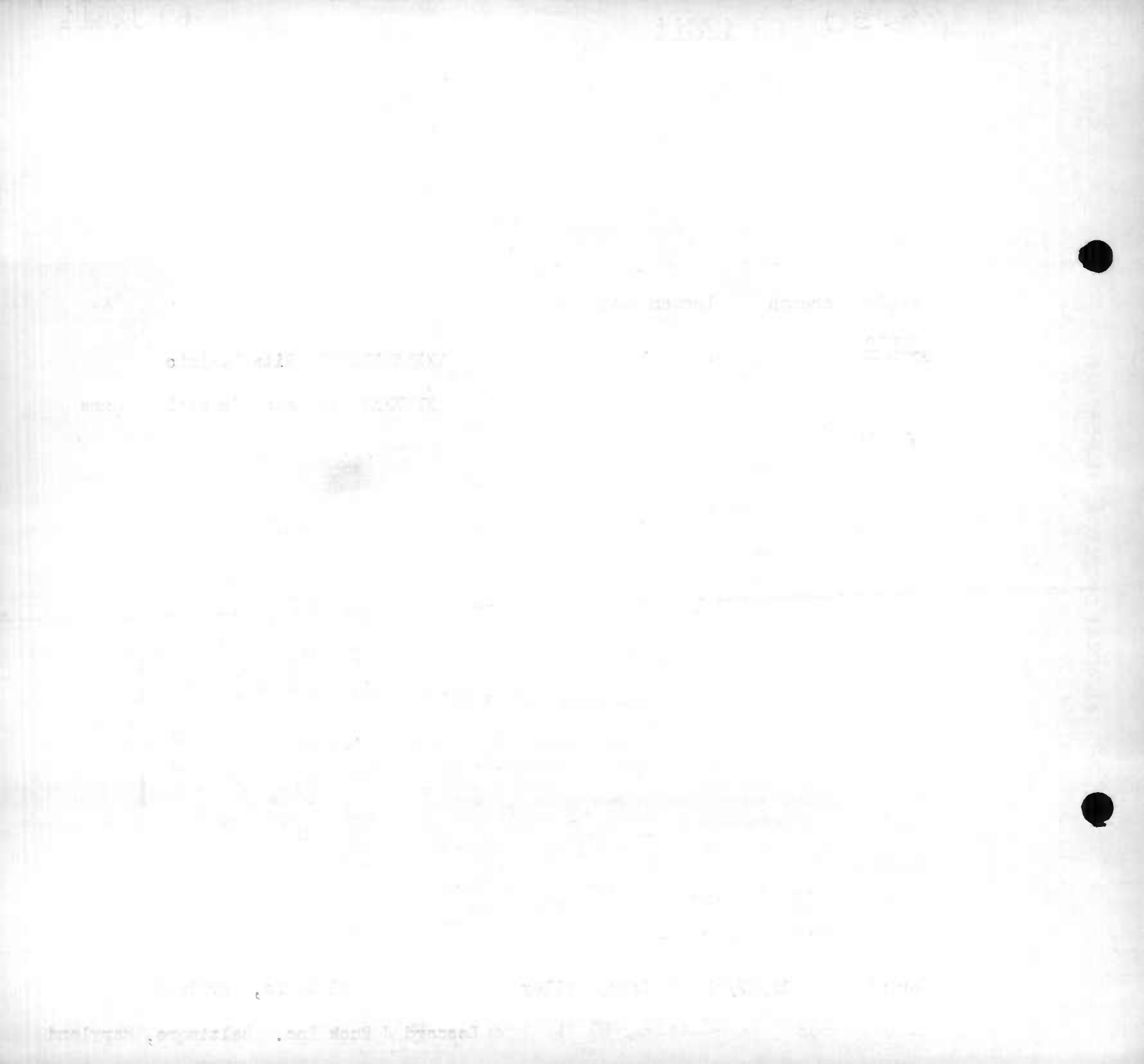




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

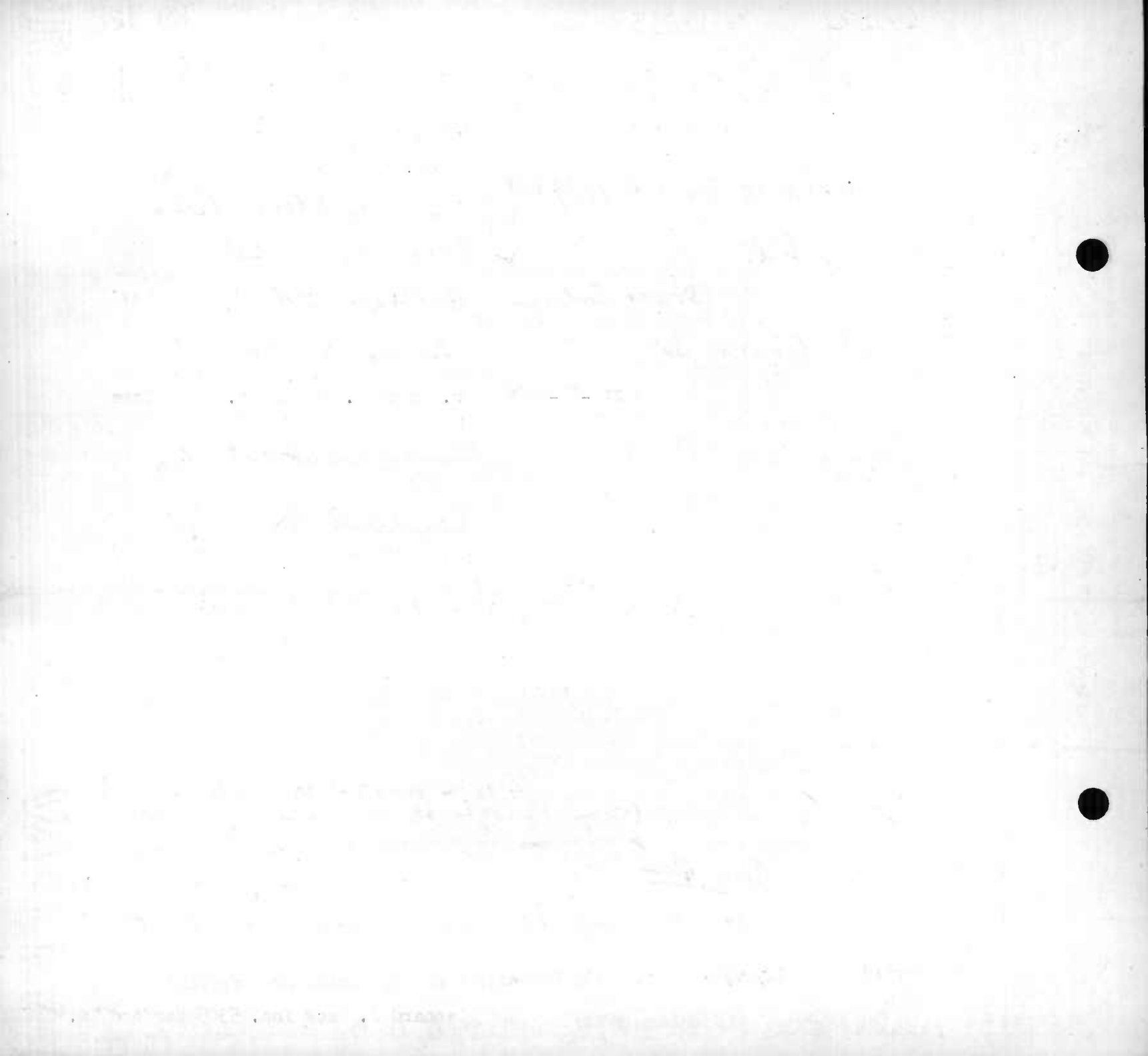
BIRTH NO. <b>69 12614</b>		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. <b>69 12614</b>	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>EUGENE MICHETTI</b>		2. DATE AND HOUR OF DEATH <b>12-18-69 12:30 P. M.</b>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <b>48 MARYLAND GENERAL HOSPITAL</b> <b>Baltimore, Md. 21201</b>		A. STATE <b>Md.</b> B. COUNTY <b>2759</b>			
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore 21218</b>			
		D. STREET ADDRESS (If rural, give location) <b>1520 Sheffield Rd.</b>			
5. SEX <b>MALE</b>	6. RACE <b>WHITE</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>8-29-90</b>	9. AGE (In years last birthday) <b>79</b>	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Pressing Foreman</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>London Town Mfg</b>		11. BIRTHPLACE (State or foreign country) <b>ITALY</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S. A</b>					
13. FATHER'S NAME <b>Donato MICHETTI</b>		14. MOTHER'S MAIDEN NAME <b>Rita DiNisio</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>212-09-6851</b>		17. INFORMANT <b>Mrs Lena Michetti</b> ADDRESS <b>Same</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b> <b>CARCINOMATOSIS, GASTRIC ORIGIN</b>		INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <b>NO</b>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from <b>12-3-69</b> to <b>12-18-69</b> , that (1) (we) last saw the deceased alive on <b>12-18-69</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Ramon Roto</b>		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <b>12/18/69</b>	
23C. PHYSICIAN'S NAME (Type) <b>RAMON ROTO</b>		23D. ADDRESS <b>701 ST PAUL ST BALTO 21202</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12/22/69</b>		24C. NAME of CEMETERY or CREMATORY <b>Dulaney Valley</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>					
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 23 1969</b>		25B. NAME OF REGISTRAR <b>Robert E. Fisher, MD.</b>		25C. FUNERAL DIRECTOR <b>Leonard J. Ruck Inc.</b>	
				ADDRESS <b>Baltimore, Maryland</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

C-550		69 12615		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 69 12615		
1. NAME OF DECEASED (Type or Print) <b>FRANK ANTHONY CIMINO JR</b>				2. DATE AND HOUR OF DEATH <b>12-19-69 6:25 a.m.</b>				
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>South Baltimore General Hospital</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>2757</b>				
				C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
				E. STREET AND NUMBER <b>7210 Hartford Road</b>				
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <b>3-18-49</b>	9. AGE (In years last birthday) <b>20</b>	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY <b>Driver Salesman</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		
13. FATHER'S NAME <b>Frank Cimino Sr</b>				14. MOTHER'S MAIDEN NAME <b>Louise Sinatra</b>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>215-54-0165</b>		17. INFORMANT <b>Mr. Frank A. Cimino Sr.</b>		ADDRESS <b>Same</b>		
18. <b>430.9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last,  <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Subarachnoid hemorrhage</b> (B) DUE TO, OR AS A CONSEQUENCE OF: <b>Cerebral Aneurysm</b> (C) _____				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?				
22. I certify that <b>we</b> (this hospital) attended the deceased from <b>4:35 pm 12-13-1969</b> to <b>6:25 am 12-19-1969</b> , that <b>we</b> (we) last saw the deceased alive on <b>6:25 am 12-19-1969</b> , and that in <b>my</b> (our) opinion death occurred on the date and hour and from the causes stated above. <b>we</b> (We) (did <del>not</del> ) view the body after death.								
23A. SIGNATURE <b>Henry Chen</b>				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>12-19-69</b>		
23C. PHYSICIAN'S NAME (Type) <b>HENRY CHEN</b>				23D. ADDRESS <b>3001 S. Hanover Street</b>				
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12/22/69</b>		24C. NAME OF CEMETERY or CREMATORY <b>Most Holy Redeemer Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore Maryland</b>		
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 23 1969</b>		25B. NAME OF REGISTRAR <b>John E. Taylor, M.D.</b>		25C. FUNERAL DIRECTOR <b>Leonard J. Buck Inc.</b>		ADDRESS <b>5305 Harford Rd. 21214</b>		



69 12616				BALTIMORE CITY HEALTH DEPARTMENT			
MEDICAL EXAMINER'S CERTIFICATE OF DEATH				REG. NO. 69 12616			
BIRTH NO.							
1. NAME OF DECEASED (Type or Print) <b>JOSEPHINE Mc CALLISTER</b>				2. DATE OF DEATH Known <input type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour <b>12 18 69 12:10 a.</b>			
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>39 Provident Hospital</b>				3. DATE PRONOUNCED DEAD Month Day Year Hour <b>Dec. 18, 1969 12:10 a.m.</b>			
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				5. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>1301</b>			
6. SEX <b>Female</b>	7. RACE <b>Negro</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Balto.</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
9. DATE OF BIRTH <b>9-1-1910</b>		10. AGE (In years last birthday) <b>59</b>		E. STREET AND NUMBER <b>804 Chauncey Terrace</b>			
11. BIRTHPLACE (State or foreign country) <b>Florence, S. C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Alec Timmons</b>			
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		14B. KIND OF BUSINESS OR INDUSTRY		15. MOTHER'S MAIDEN NAME <b>Millie ?</b>			
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>		17. SOCIAL SECURITY NO.		18. INFORMANT ADDRESS <b>Jimmie McCallister - 804 Chauncey</b>			
19. <b>412,412-2509</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>Arteriosclerotic cardiovascular disease</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) _____ (C) _____ DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>Diabetes Mellitus</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED				21. AUTOPSY? (Yes or No) <b>No</b>	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID IT IN BALTIMORE CITY, GIVE EXACT LOCATION) INJURY OCCUR?			
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE <b>Isidore Mihalakis, M.D.</b> M.D. DATE SIGNED EXAMINER'S NAME (Type)							
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12-22-69</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Carver Memorial Park</b>		24D. LOCATION (City, town, or county) (State) <b>Laurel, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 23 1969</b>		25B. NAME OF REGISTRAR <b>Robert E. Fisher, M.D.</b>		25C. FUNERAL DIRECTOR <b>Charles R. Law</b>		ADDRESS <b>802 Madison Ave.</b>	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

C-653		69 12617		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 69 12617	
BIRTH NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>Mathie Bell CORNETT</u>				2. DATE AND HOUR OF DEATH <u>12-20-69</u> <u>6.30 P.</u> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <u>MD</u> B. COUNTY <u>2544</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>43 South BALT. more General Hospital</u>				C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <u>922 Dantrey Ct #25</u>			
5. SEX <u>Female</u>	6. RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11-6-1907</u>	9. AGE (In years last birthday) <u>62</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>KENTUCKY</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>BIDGE HOSKINS</u>				14. MOTHER'S MAIDEN NAME <u>ALICE HOSKINS</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NA</u>				16. SOCIAL SECURITY NO. <u>404-09-5980</u>		17. INFORMANT <u>Vivian Seiler</u> ADDRESS <u>805 Cedar Branch Dr. Glen Burnie, Md.</u>	
18. <u>200.1</u> I CAUSE OF DEATH				DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE <u>Lympho Sarcoma</u> DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES				(B) _____ DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C) _____			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examined) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>11-24-</u> 19 <u>69</u> to <u>12-20-</u> 19 <u>69</u> that (I) (we) last saw the deceased alive on <u>12-20-</u> 19 <u>69</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Nabil Yacoub Younan</u>				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>12-20-69</u>	
23C. PHYSICIAN'S NAME (Type) <u>Younan Y. Nabil Yacoub</u>				23D. ADDRESS <u>South Baltimore General Hospte</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>12/26/69</u>		24C. NAME OF CEMETERY or CREMATORY <u>Cornett Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Dione, Kentucky</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>DEC 23 1969</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>		25C. FUNERAL DIRECTOR <u>Raymond C. Fink</u>		ADDRESS <u>Glen Burnie, Md.</u>	

W. H. H. H.

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W. H. H. H.

W. H. H. H.



## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

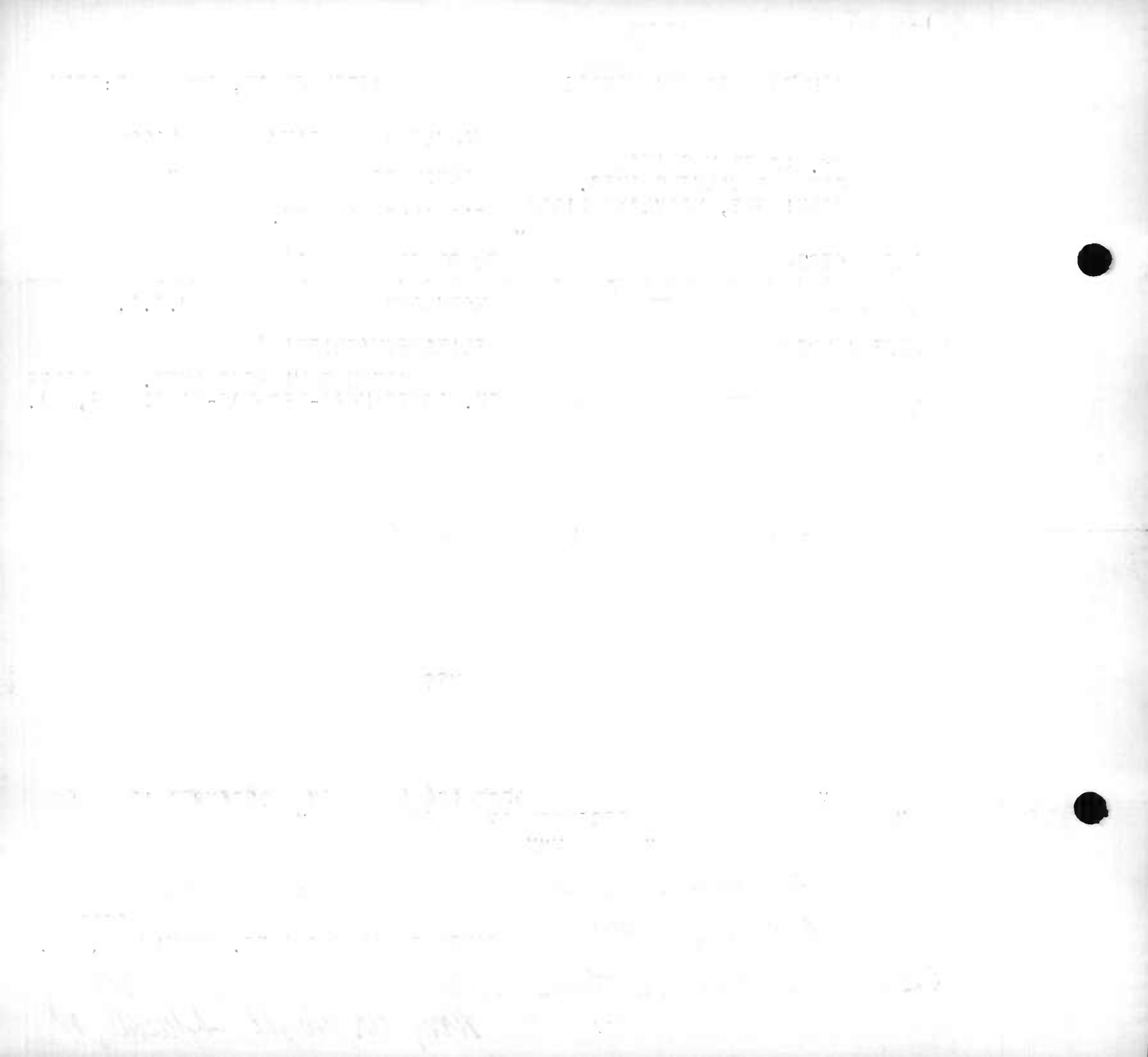
4-545 69-03860 12618		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 69 12618	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>Bernald Henline</u>		2. DATE AND HOUR OF DEATH <u>12-16-69</u> <u>1:08 P.</u> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Johns Hopkins Hospital</u>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MD</u> B. COUNTY <u>Prince George</u> <u>6600</u>		C. CITY OR TOWN <u>Beltsville</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <u>M</u> 6. RACE <u>W</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2-27-69</u> 9. AGE (In years last birthday) <u>19 mo</u>		10. BIRTHPLACE (State or foreign country) <u>Brooklyn, Md</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Bernald</u>		14. MOTHER'S MAIDEN NAME <u>Denna Hausen</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT <u>Parents</u>		ADDRESS	
18. <u>03891</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Cardiorespiratory arrest</u> (B) <u>probable sepsis</u> DUE TO, OR AS A CONSEQUENCE OF: (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>45 minute</u> <u>? 12 hrs</u>	
MEDICAL CERTIFICATION					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>Yes</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>19</u> to <u>19</u> , that (I) (we) lost saw the deceased alive on <u>19</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Robert Suskind MD</u>		23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type) <u>Robert Suskind</u>	
23D. ADDRESS <u>Johns Hopkins Hospital</u>		23E. DEGREE <u>MD</u>		23F. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>12-19-69</u>		24C. NAME OF CEMETERY or CREMATORY <u>Oakland Cemetery</u>	
24D. LOCATION <u>Baltimore, Md.</u>		24E. NAME OF REGISTRAR <u>Johns Hopkins Hospital</u>		24F. FUNERAL DIRECTOR <u>Monmouth Funeral Home</u>	
24G. DATE REC'D BY HEALTH DEPT. <u>DEC 23 1969</u>		24H. NAME OF REGISTRAR <u>Johns Hopkins Hospital</u>		24I. ADDRESS <u>Monmouth Funeral Home, Md.</u>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

J-525		69 12619		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 69 12619	
BIRTH NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>JOHNSON, BERNARD MONROE</b>				2. DATE AND HOUR OF DEATH <b>DECEMBER 17, 1969 2:30AM</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>CITY</b>			
FULL NAME OF HOSPITAL OR INSTITUTION <b>ST. AGNES HOSPITAL</b> <b>CATON &amp; WILKENS AVES.</b> <b>BALTIMORE, MARYLAND 21229</b>				C. CITY OR TOWN <b>BALTIMORE</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <b>MALE</b> 6. RACE <b>NEGRO</b> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH <b>08 07 53</b>		9. AGE (In years last birthday) <b>16</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Student</b>				10B. KIND OF BUSINESS OR INDUSTRY <b>-</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
13. FATHER'S NAME <b>MONROE JOHNSON</b>				14. MOTHER'S MAIDEN NAME <b>ELIZABETH(GRIFFIN)</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>-</b>		17. INFORMANT <b>CATON &amp; WILKENS AVES. ADDRESS 21229 ST. AGNES HOSP-RECORDS-BALTIMORE, MD.</b>	
18. <b>I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
				(A) IMMEDIATE CAUSE <b>sickle cell anemia</b> DUE TO, OR AS A CONSEQUENCE OF:			
				(B) <b>Broncho-Pneumonia</b> DUE TO, OR AS A CONSEQUENCE OF:			
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>YES</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR			
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>DECEMBER 8 1969</b> to <b>DECEMBER 17 1969</b> that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>DECEMBER 17 1969</b> and that <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) (do) view the body after death.							
23A. SIGNATURE <b>A. Sham...</b>				23B. DATE SIGNED <b>12-17-69</b>			
23C. PHYSICIAN'S NAME (Type) <b>A. Sham...</b>				23D. ADDRESS <b>CATON &amp; WILKENS AVES. BALTIMORE, MD. 21229</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12-20-69</b>		24C. NAME OF CEMETERY or CREMATORY <b>Crestlawn Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Howard Co. Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 23 1969</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor, Md.</b>		25C. FUNERAL DIRECTOR <b>Harry W. Haight, Sylvanville, Md.</b>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

11-635 69 12620 BIRTH NO. 69-23597		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 69 12620	
1. NAME OF DECEASED (Type or Print) <b>BABY GIRL MARTIN</b>			2. DATE AND HOUR OF DEATH <b>DECEMBER 20, 1969 10<sup>10</sup> P.M.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>48 Md. Gen. Hosp.</b>			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>md.</b> B. COUNTY <b>1207</b>		
5. SEX <b>FEMALE</b>			6. RACE <b>W</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH <b>DEC. 20, 1969</b>
13. FATHER'S NAME <b>Calvin Martin</b>			14. MOTHER'S MAIDEN NAME <b>Edna Pithinger</b>		9. AGE (in years last birthday) <b>4</b>
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		11. BIRTHPLACE (State or foreign country) <b>md</b>
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>776.2 I Acute Severe Respiratory Distress with metabolic derangements secondary</b>			17. INFORMANT <b>MOTHER</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
19. DATE OF OPERATION <b>0</b>			20A. AUTOPSY? (Yes or No)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, locality, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <b>DEC 20 1969</b> to <b>DEC 20 1969</b> that (I) (we) last saw the deceased alive on <b>DEC 20 1969</b> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Virgilio O. Javier</b>			23B. DATE SIGNED <b>Dec-21-69</b>		
23C. PHYSICIAN'S NAME (Type) <b>Virgilio O. Javier</b>			23D. ADDRESS <b>Maryland General Hospital</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>			24B. DATE <b>12/22/69</b>		24C. NAME of CEMETERY or CREMATORY <b>Mt. Zion Cemetery</b>
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 23 1969</b>			25B. NAME OF REGISTRAR <b>Robert E. Barber</b>		25C. FUNERAL DIRECTOR <b>Ann Donovan</b> ADDRESS <b>3818 Roland Ave.</b>



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <b>69 12621</b>	
BIRTH NO. <b>D-540</b>		69 12621 <b>CERTIFICATE OF DEATH</b>	
1. NAME OF DECEASED (Type or Print) <b>LILIAN DE MELL D</b>		2. DATE AND HOUR OF DEATH <b>12-18-69</b> <b>655 A.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION <b>NORTH CHARLES GENERAL HOSPITAL</b>  (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>Baltimore</b> C. CITY OR TOWN <b>21224</b> D. INSIDE CITY LIMITS? <b>5300</b> <b>BALTIMORE</b> YES <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER <b>7399 BELMONT AVE</b>	
5. SEX <b>FEMALE</b>	6. RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7-22-1876</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSE WIFE</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>HOME</b>	11. BIRTHPLACE (State or foreign country) <b>POLAND</b>
13. FATHER'S NAME <b>JOSEPH YABUSEESKI</b>		14. MOTHER'S MAIDEN NAME <b>AMELIA?</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>230-30-0579</b>	
17. INFORMANT <b>Frank Brush- Son</b>		ADDRESS <b>Same</b>	
18. <b>1950</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>CARCINOMATOSIS</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. <b>INTRABDOMINAL</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>4 YEARS</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION <b>0</b>	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) <input checked="" type="checkbox"/>	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>12/13/1969</b> to <b>12/18/1969</b> , that (I) (we) lost saw the deceased alive on <b>12/18/1969</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <b>TEODORO R. CARANGAL</b> DEGREE		23B. DATE SIGNED <b>12-18-69</b>	
23C. PHYSICIAN'S NAME (Type) <b>TEODORO R. CARANGAL</b> DEGREE		23D. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>12/22/69</b>	24C. NAME OF CEMETERY or CREMATORY <b>Baltimore National Cemetery</b>	24D. LOCATION (City, town, or county) (State) <b>Baltimore Co., Md.</b>
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 23 1969</b>	25B. NAME OF REGISTRAR <b>Robert E. Taylor, M.D.</b>	25C. FUNERAL DIRECTOR <b>Brudzinski Funeral Home</b> ADDRESS <b>1407 Eastern Ave.</b>	





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<div style="display: flex; justify-content: space-between;"> <span>69 12622</span> <span>BALTIMORE CITY HEALTH DEPARTMENT</span> </div> <h2 style="text-align: center;">CERTIFICATE OF DEATH</h2> <div style="display: flex; justify-content: space-between;"> <span>REG. NO. 69 12622</span> </div>	
BIRTH NO. <span style="font-size: 1.5em;">X-152</span>	
1. NAME OF DECEASED (Type or Print) <span style="font-size: 1.2em;">KATHERINE ROBINSON</span>	
2. DATE AND HOUR OF DEATH <span style="font-size: 1.2em;">DEC. 21, 1969 2:10 A.M.</span>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <span style="font-size: 1.2em;">MONTEBELLO STATE HOSPITAL, BALTIMORE, MD.</span>	
4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <span style="font-size: 1.2em;">BALTO. MD.</span> B. COUNTY <span style="font-size: 1.2em;">1403</span>	
C. CITY OR TOWN <span style="font-size: 1.2em;">BALTO.</span> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <span style="font-size: 1.2em;">1810 EUTAW PLACE</span>	
5. SEX <span style="font-size: 1.2em;">F</span>	6. RACE <span style="font-size: 1.2em;">negro</span>
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <span style="font-size: 1.2em;">2/12/09</span>	9. AGE (in years last birthday) <span style="font-size: 1.2em;">60</span>
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">Housewife</span>	
11. BIRTHPLACE (State or foreign country) <span style="font-size: 1.2em;">Va.</span>	
12. CITIZEN OF WHAT COUNTRY? <span style="font-size: 1.2em;">U.S.A.</span>	
13. FATHER'S NAME <span style="font-size: 1.2em;">Jas. Watkins</span>	
14. MOTHER'S MAIDEN NAME <span style="font-size: 1.2em;">Victoria Horton</span>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <span style="font-size: 1.2em;">no</span>	
16. SOCIAL SECURITY NO. <span style="font-size: 1.2em;">24-12-2847</span>	
17. INFORMANT <span style="font-size: 1.2em;">Josephine Clark</span> ADDRESS <span style="font-size: 1.2em;">1810 Eutaw Pl</span>	
18. <span style="font-size: 1.2em;">433.04 250.9</span> CAUSE OF DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.	
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <span style="font-size: 1.2em;">CEREBRAL THROMBOSIS</span>	
(B) <span style="font-size: 1.2em;">ARTERIOSCLEROSIS</span> DUE TO, OR AS A CONSEQUENCE OF:	
(C) <span style="font-size: 1.2em;">HYPERTENSION</span>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <span style="font-size: 1.2em;">DIABETES MELLITUS</span>	
19A. DATE OF OPERATION <span style="font-size: 1.2em;">0</span> 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) <span style="font-size: 1.2em;">No</span> 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <span style="font-size: 1.2em;">8-26</span> 19 <span style="font-size: 1.2em;">68</span> to <span style="font-size: 1.2em;">12-21</span> 19 <span style="font-size: 1.2em;">69</span> that (I) (we) last saw the deceased alive on <span style="font-size: 1.2em;">12-21</span> 19 <span style="font-size: 1.2em;">69</span> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.	
23A. SIGNATURE <span style="font-size: 1.2em;">Irving L. Cooperstein</span> 23B. DATE SIGNED <span style="font-size: 1.2em;">12-21-69</span>	
23C. PHYSICIAN'S NAME (Type) <span style="font-size: 1.2em;">IRVING L. COOPERSTEIN</span> 23D. ADDRESS <span style="font-size: 1.2em;">MONTEBELLO STATE HOSP. BALTO.</span>	
24A. BURIAL CREMATION, REMOVAL (Specify) <span style="font-size: 1.2em;">Burial</span> 24B. DATE <span style="font-size: 1.2em;">12/24/69</span> 24C. NAME OF CEMETERY OR CREMATORY <span style="font-size: 1.2em;">Mt. Auburn</span> 24D. LOCATION (City, town, or county) (State) <span style="font-size: 1.2em;">Baltimore Md.</span>	
25A. DATE REC'D BY HEALTH DEPT. <span style="font-size: 1.2em;">DEC 23 1969</span> 25B. NAME OF REGISTRAR <span style="font-size: 1.2em;">Robert E. Fisher, M.D.</span> 25C. FUNERAL DIRECTOR <span style="font-size: 1.2em;">Wm. G. Blanton</span> ADDRESS <span style="font-size: 1.2em;">1-1701 M.E. Coll.</span>	

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

W-420		69 12623		BALTIMORE CITY HEALTH DEPARTMENT		X		REG. NO. 69 12623	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>MAURICE E. WALSH</b>				2. DATE AND HOUR OF DEATH <b>12-19-69 1:15 A.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD						4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <b>MERCY Hospital</b> (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)						A. STATE <b>MD</b>		B. COUNTY <b>BALTIMORE</b>	
						C. CITY OR TOWN <b>DUNDALK</b>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
E. STREET AND NUMBER <b>11 DUNDALK AVE</b>									
5. SEX <b>MALE</b>	6. RACE <b>CAUCASIAN</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>NOV. 10, 1911</b>		9. AGE (In years last birthday) <b>58</b>		If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>PODIATRIST</b>				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>PENNA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>MAURICE E. WALSH</b>						14. MOTHER'S MAIDEN NAME <b>ANNA K. CASEY</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>				16. SOCIAL SECURITY NO. <b>213-07-9644</b>		17. INFORMANT <b>MARGARET D. WALSH-WIFE - SAME</b>			
18. <b>162.1 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>CANCER of the lung w/ metastases</b>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>—</b>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b>									
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).									
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <b>—</b>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <b>—</b>					
22. I certify that <del>he</del> (this hospital) attended the deceased from <b>12-01</b> 19 <b>69</b> to <b>12-19</b> 19 <b>69</b> that <del>we</del> (we) last saw the deceased alive on <b>12-18</b> 19 <b>69</b> and that <del>in my</del> (our) opinion death occurred on the date and hour and from the causes stated above <del>we</del> (We) (did) (did not) view the body after death.									
23A. SIGNATURE <b>C. E. DeFelia</b>						Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>12-19-69</b>	
23C. PHYSICIAN'S NAME (Type) <b>C. E. DeFelia</b>						23D. ADDRESS <b>MERCY Hospital</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>12-22-69</b>		24C. NAME OF CEMETERY OR CREMATORY <b>HOLY FAMILY</b>		24D. LOCATION (City, town, or county) (State) <b>BALTO. CO. MD.</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 23 1969</b>		25B. NAME OF FUNERAL DIRECTOR <b>Robert E. ...</b>		25C. FUNERAL DIRECTOR <b>10, ...</b>		ADDRESS <b>...</b>			



W-325

69 12624

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 69 12624

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Elizabeth M. Watson

2. DATE  
OF  
DEATHKnown ☐  
Estimated ☐

Month

Day

Year

Hour

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
OR INSTITUTION ADDRESS OR LOCATION)

Maryland General Hospital (DOA)

3. DATE  
PRONOUNCED DEAD

Month

Day

Year

Hour

12

15

69

1:02 A.M.

5. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)

A. STATE

B. COUNTY

Md.

1101

6. SEX

Female

7. RACE

White

B. MARRIED ☒NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

C. CITY OR TOWN

Balto.

D. INSIDE CITY LIMITS?

YES ☒NO ☐

9. DATE OF BIRTH

July 11th, 1944

10. AGE (In years  
last birthday)If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.

25

E. STREET AND NUMBER

1101 St. Paul St.

11. BIRTHPLACE (State or foreign country)

Iowa

12. CITIZEN OF

WHAT COUNTRY?

USA

13. FATHER'S NAME

Isadore V. Kuhn

14A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Buyer-Hecht Co.

14B. KIND OF BUSINESS OR INDUSTRY

Dept. Store

15. MOTHER'S MAIDEN NAME

Lillian Danese

16. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

no

17. SOCIAL  
SECURITY NO.

479-54-6667

18. INFORMANT

ADDRESS

Stephen L. Watson-1101 St. Paul

19. E 812.1

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)

Multiple traumatic injuries

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

MEDICAL CERTIFICATION

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART I (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

yes

22A. EXTERNAL CAUSE WAS  
UNDERLYING ☒ OR CONTRIB-  
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about  
home; farm, factory, street, office bldg., etc.)

street

22C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?

Park Avenue and Monument St.

22D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY (APPROX.)

12

15

69

12:52

22E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☒

22F. HOW DID INJURY OCCUR?

Subject passenger in auto-auto collision.

23.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL

SIGNATURE

EXAMINER'S

NAME (Type)

Russell S. Fisher, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☒ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

12-15-69

24A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

12/18/69

24C. NAME of CEMETERY or CREMATORY

24D. LOCATION

(City, town, or county)

(State)

Iowa

25A. DATE REC'D BY HEALTH DEPT.

DEC 23 1969

25B. NAME OF REGISTRAR

Robert E. Fisher, M.D.

25C. FUNERAL DIRECTOR

Walters Fun. Home-Anthon, Iowa  
Mitchell-Wiederfeld Home, Balto. MD.

ADDRESS

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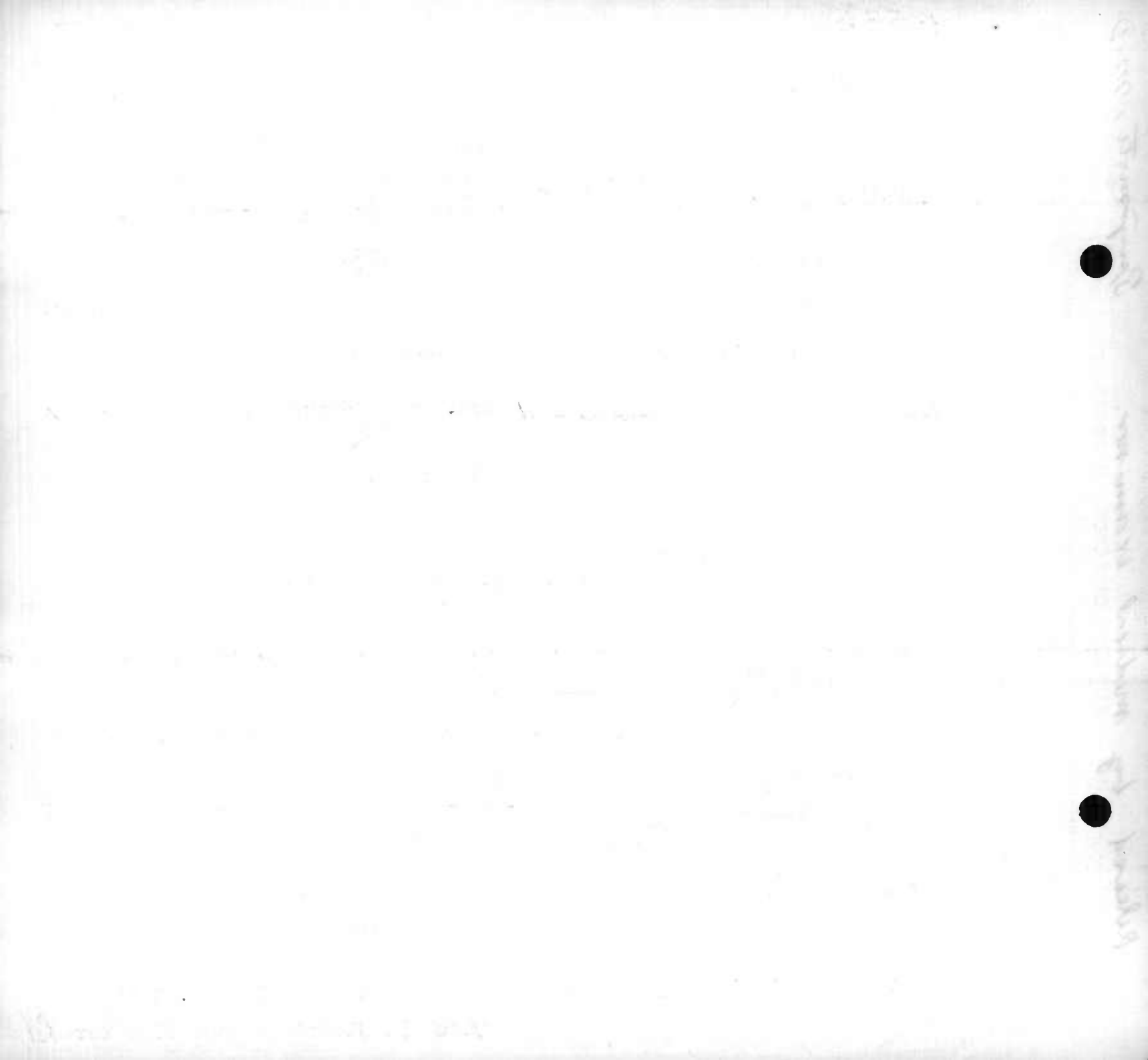
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100-100000

Released by medical examiner.  
Funeral Director: Important

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

A-536		69 12625		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		REG. NO. 69 12625	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) ANDRONICOS, PETER				2. DATE AND HOUR OF DEATH 12-15-1969 4:00 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY U.S.A.				2744			
FULL NAME OF HOSPITAL OR INSTITUTION 44 UNION MEMORIAL HOSPITAL		C. CITY OR TOWN BALTIMORE				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
5. SEX M		6. RACE GREEK		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8-18-1884		9. AGE (In years lost birthday) 85	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) GREECE		12. CITIZEN OF WHAT COUNTRY? AMERICAN			
13. FATHER'S NAME EMMANUEL ANDRONICOS				14. MOTHER'S MAIDEN NAME Stavroula					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 212-32-2571		17. INFORMANT Mrs. Anne Hegarty 1302 Regester Ave				ADDRESS	
18. E887X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) ACUTE SUBDURAL HEMATOMA		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 DAYS					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. FRACTURE OF SKULL, RIGHT SIDE				3 DAYS					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).									
19A. DATE OF OPERATION 12-12-1969		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Fractured skull, Subdural Hematoma		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input checked="" type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) IN HOME		21C. WHERE DID INJURY OCCUR? 5910 CARTER AVENUE, BALTIMORE		(If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) 12-12-1969		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from 12-12-1969 to 12-15-1969		that (I) (we) last saw the deceased alive on 4:00 PM 12-15-1969		and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Kasuke Tsujimoto, M.D.		23B. DATE SIGNED 12-15-1969		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>					
23C. PHYSICIAN'S NAME (Type) KASUKE TSUJIMOTO		23D. ADDRESS UNION MEMORIAL HOSPITAL 33 RD AND CALVERT STS. BALTIMORE							
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/17/69		24C. NAME of CEMETERY or CREMATORY Greek Orthodox Cemetery		24D. LOCATION Windsor Mill Rd. Balto M		(City, town, or county) (State)	
25A. DATE REC'D BY HEALTH DEPT. DEC 23 1969		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.		25C. FUNERAL DIRECTOR Mitchell Giedefeld		Home 6500 York Rd			





FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 69 12626	
M-563 69 12626		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <i>Anna Maynard</i>		2. DATE AND HOUR OF DEATH <i>12-19-69</i> <i>7 P</i> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, If institution; residence before admission) A. STATE <i>MD</i> B. COUNTY <i>908</i>	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>Bolton Hill Nursing &amp; Convalescent Center</i>		C. CITY OR TOWN <i>BALTIMORE</i> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <i>F</i> 6. RACE <i>W</i> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>8-22-86</i> 9. AGE (In years last birthday) <i>83 yrs</i>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country) <i>Pennsylvania</i>	
10B. KIND OF BUSINESS OR INDUSTRY <i>Anderson Dry Cleaning Co.</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>John Rapp</i>		14. MOTHER'S MAIDEN NAME <i>Louisa Deyle</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>no</i>		16. SOCIAL SECURITY NO. <i>212-34-9528</i>	
17. INFORMANT <i>Mr. Henry W. Spriggs</i>		ADDRESS <i>5923 Chinquapin Pkwy.</i>	
18. <i>412.3 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE <i>Pneumonia</i> DUE TO, OR AS A CONSEQUENCE OF:	
		(B) <i>arteriosclerosis heart disease</i> DUE TO, OR AS A CONSEQUENCE OF: <i>years</i>	
		(C) <i>arteriosclerosis, gen</i> DUE TO, OR AS A CONSEQUENCE OF: <i>years</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>8/15</i> 1967 to <i>12/19</i> 1969, that (I) (we) last saw the deceased alive on <i>12/19</i> 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <i>ae Maert</i>		23B. DATE SIGNED <i>12/20/69</i>	
23C. PHYSICIAN'S NAME (Type) <i>ALLAN H. MAERT MD</i>		23D. ADDRESS <i>215 Red St Baltimore Md</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>12/22/69</i>	
24C. NAME OF CEMETERY OR CREMATORY <i>Oaklawn Cemetery</i>		24D. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>DEC 23 1969</i>		25B. NAME OF REGISTRAR <i>Robert E. Taylor M.D.</i>	
25C. FUNERAL DIRECTOR <i>Mitchell-Wiedefeld Home</i>		ADDRESS <i>6500 York Rd.-12</i>	

22  
14

63  
64

Department of Education, U.S. Government

Division of Vocational Education

Washington, D.C.

U.S. Government Printing Office

Washington, D.C.

1940-1941 Yearbook

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

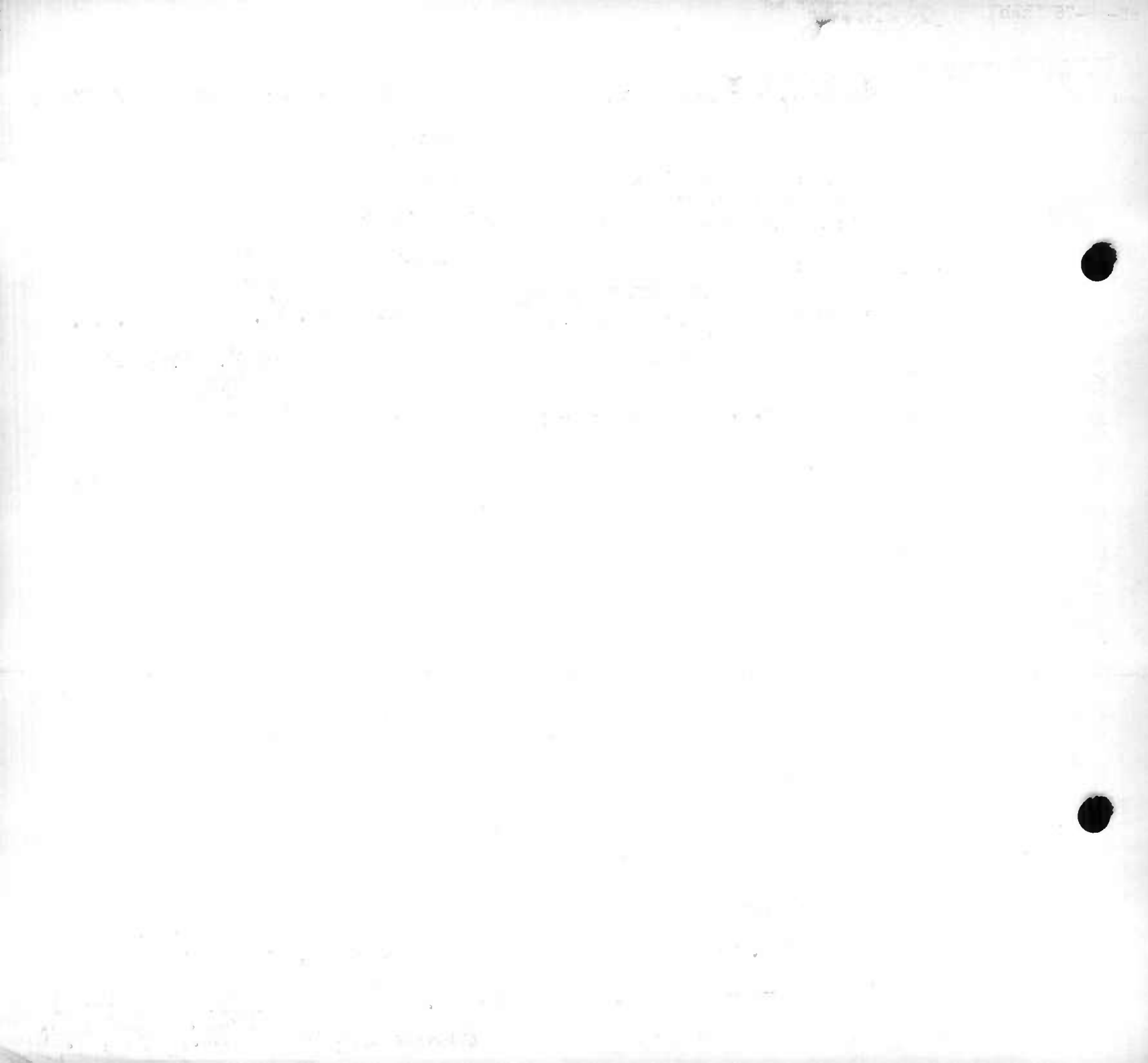
BALTIMORE CITY HEALTH DEPARTMENT											
69 12627 CERTIFICATE OF DEATH											
REG. NO. 69 12627											
1. NAME OF DECEASED (Type or Print) <b>FRANCIS PETERSEN</b>				2. DATE AND HOUR OF DEATH <b>DECEMBER 20, 1969 2:00 PM.</b>							
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)							
FULL NAME OF HOSPITAL OR INSTITUTION <b>UNION MEMORIAL HOSPITAL 44</b>				(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE <b>MARYLAND</b>			
								B. COUNTY <b>BALTO. CO.</b>			
				C. CITY OR TOWN <b>TOWSON</b>				D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
				E. STREET AND NUMBER <b>14 ACORN CIRCLE</b>							
5. SEX <b>MALE</b>		6. RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>JAN 22, 1896</b>		9. AGE (In years last birthday) <b>73</b>		If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Sales Rep.</b>				10B. KIND OF BUSINESS OR INDUSTRY <b>Reed &amp; Barton</b>				11. BIRTHPLACE (State or foreign country) <b>NEW YORK</b>			
								12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>JULIUS PETERSEN</b>				14. MOTHER'S MAIDEN NAME <b>MARY ELIZABETH ROLAND</b>							
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes WW-1</b>				16. SOCIAL SECURITY NO. <b>063-07-3524</b>				17. INFORMANT <b>ROXANNE PETERSEN</b>			
								ADDRESS <b>14 ACORN CIRCLE TOWSON, MD.</b>			
18. <b>1971 I</b> CAUSE OF DEATH											
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH											
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)											
ANTECEDENT CAUSES											
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.											
(A) IMMEDIATE CAUSE <b>ADENOCARCINOMA OF LIVER</b>											
DUE TO, OR AS A CONSEQUENCE OF: <b>PRIMARY SITE, UNKNOWN</b>											
(B) DUE TO, OR AS A CONSEQUENCE OF:											
(C) DUE TO, OR AS A CONSEQUENCE OF:											
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).											
19A. DATE OF OPERATION <b>DEC 12, 1969</b>				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>BIOPSY</b>				20A. AUTOPSY? (Yes or No) <b>NO</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>DEC 20, 1969</b> to <b>DEC 20, 1969</b> that (I) (we) last saw the deceased alive on <b>DEC 20, 1969</b> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE <b>[Signature]</b>								23B. DATE SIGNED <b>12-20-69</b>			
23C. PHYSICIAN'S NAME (Type) <b>Y.H. SUI LIT</b>								23D. ADDRESS <b>MD UNION MEMORIAL HOSPITAL, BALTO., MD.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>				24B. DATE <b>12/23/69</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Druid Ridge Cemetery</b>				24D. LOCATION (City, town, or county) (State) <b>Balto.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 23 1969</b>				25B. NAME OF REGISTRAR <b>Robert E. Taylor, M.D.</b>				25C. FUNERAL DIRECTOR <b>Mitchell-Wiedefeld</b>			
								ADDRESS <b>Home-6500 York Rd-12</b>			



## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

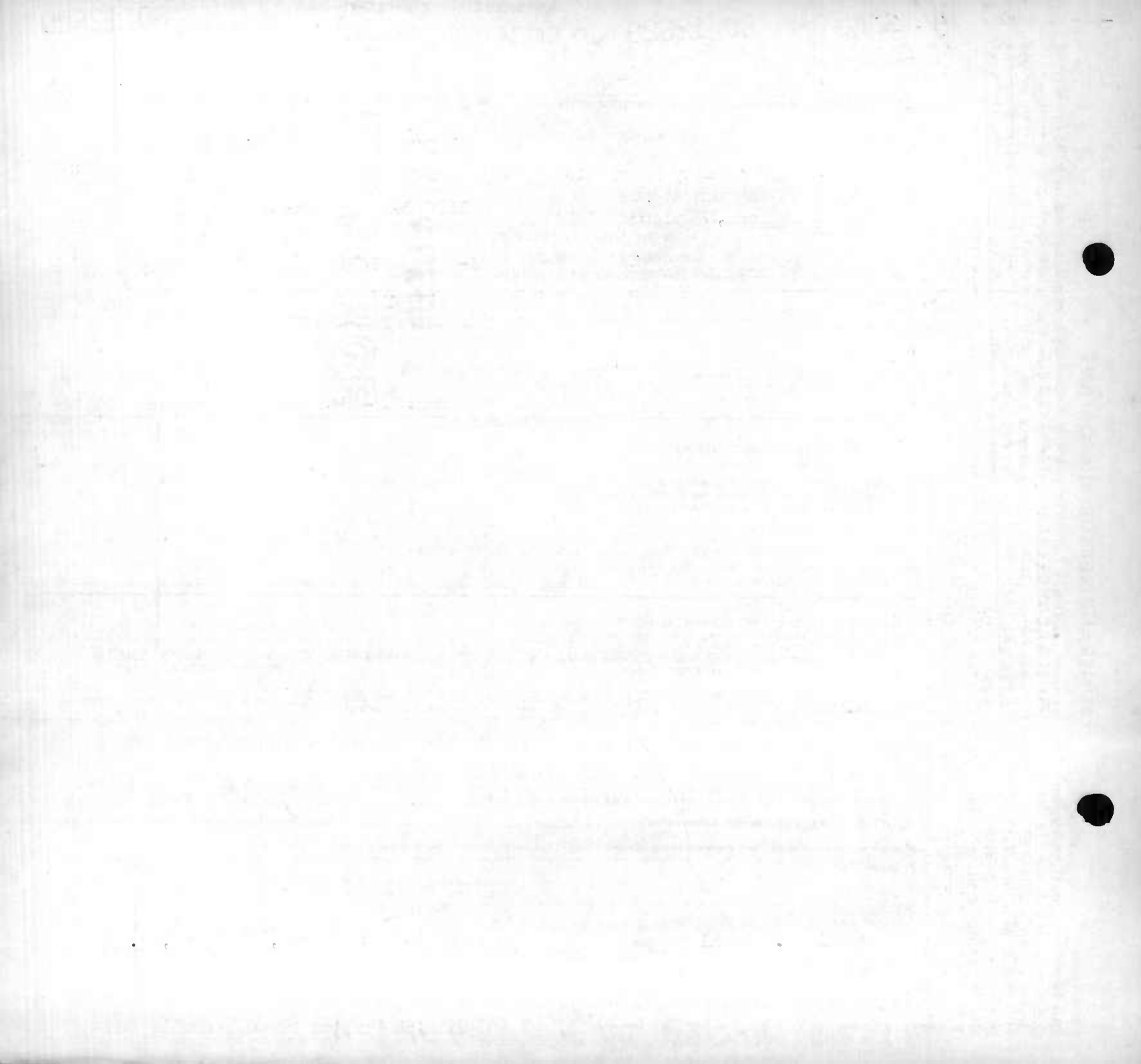
B-620		69 12628		CITY HEALTH DEPARTMENT		REG. NO. 69 12628	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>Anthony L. Gross SR.</u>				2. DATE AND HOUR OF DEATH <u>DECEMBER 18, 1969 9:41 P.M.</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>31 Baltimore City Hospitals</u> <u>4940 Eastern Avenue</u> <u>Baltimore, Maryland 21224</u>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE <u>Maryland</u>		B. COUNTY	
C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		E. STREET AND NUMBER <u>3608 Fait Avenue 2124</u>			
5. SEX <u>Male</u>	6. RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12-23-1919</u>		9. AGE (In years last birthday) <u>49</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Chauffeur</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Hillgartner Marble and Granite Co.</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore . Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Anthony Gross</u>				14. MOTHER'S MAIDEN NAME <u>Florence M. Fitzgerald</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>Yes W.W.II</u>		16. SOCIAL SECURITY NO. <u>215-03-6959</u>		17. INFORMANT ADDRESS <u>Records: BCH-4940 Eastern Avenue 21224</u>			
18. <u>4-27-21</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>CAUSE OF DEATH</u> (A) IMMEDIATE CAUSE <u>CARDIORESPIRATORY ARREST 1 HR</u> DUE TO, OR AS A CONSEQUENCE OF: (B) _____ DUE TO, OR AS A CONSEQUENCE OF: (C) _____				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>II</u>							
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>YES</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>YES</u>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (1) (this hospital) attended the deceased from <u>DECEMBER 18, 1969</u> to <u>DECEMBER 18, 1969</u> that (1) (we) last saw the deceased alive on <u>DECEMBER 18, 1969</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Michael M. McConnell, M.D.</u>				23B. DATE SIGNED <u>DECEMBER 18, 1969</u>		23C. PHYSICIAN'S NAME (Type) <u>Michael M. McConnell</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>12-22-69</u>		24C. NAME of CEMETERY or CREMATORY <u>Gardens of Faith Cem.</u>		24D. LOCATION (City, town, or county) (State) <u>BALTO. CO., MD. Kenwood Av. and Trump Mill Rd.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>DEC 23 1969</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>		25C. FUNERAL DIRECTOR <u>Charles S. Zeller</u>		25D. ADDRESS <u>901 S. Conkling St. Balto., 21224, Md.</u>	



FUNERAL DIRECTOR: IMPORTANT

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BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>AMELIA YEAGER</b>		2. DATE AND HOUR OF DEATH <b>12/18/69 8<sup>29</sup> A. M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>31 Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224</b>				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b> C. CITY OR TOWN <b>Dundalk</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER <b>1506 Delvale Avenue 21222</b>	
5. SEX <b>Female</b>	6. RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4-1885</b>	9. AGE (In years last birthday) <b>84</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>At home</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Germany</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			13. FATHER'S NAME <b>Frederick Buckum</b>		
14. MOTHER'S MAIDEN NAME <b>?</b>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No.</b>		
16. SOCIAL SECURITY NO. <b>214-54-4032</b>			17. INFORMANT <b>Records: BCH-4940 Eastern Avenue 21224</b>		
18. <b>410.9 I</b> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Myocardial Infarction</b> minutes (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Arteriosclerotic Cardiovascular Disease</b> years (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____					
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>II</b>					
19A. DATE OF OPERATION <b>2/11/69</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>GANGRENE</b>		20A. AUTOPSY? (Yes or No) <b>YES</b>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>YES</b>		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (H) (this hospital) attended the deceased from <b>11/10</b> 19 <b>69</b> to <b>12/18</b> 19 <b>69</b> , that (H) (we) last saw the deceased alive on <b>12/18</b> 19 <b>69</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Dennis W. Bleakley MD</b>				23B. DATE SIGNED <b>12/18/69</b>	
23C. PHYSICIAN'S NAME (Type) <b>Dennis W. Bleakley</b>				23D. ADDRESS <b>Baltimore City Hospitals 4940 Eastern Avenue, Baltimore, Md. 21224</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12/20/69</b>		24C. NAME of CEMETERY or CREMATORY <b>Oak Lawn Cemetery</b>	
24D. LOCATION <b>Baltimore Co. Md.</b>		24E. DATE REC'D BY HEALTH DEPT.			
25A. NAME OF REGISTRAR <b>DEC 23 1969</b>		25B. NAME OF REGISTRAR <b>Ulrich Funeral Home. Dundalk, Md.</b>		25C. FUNERAL DIRECTOR <b>Ulrich Funeral Home. Dundalk, Md.</b>	

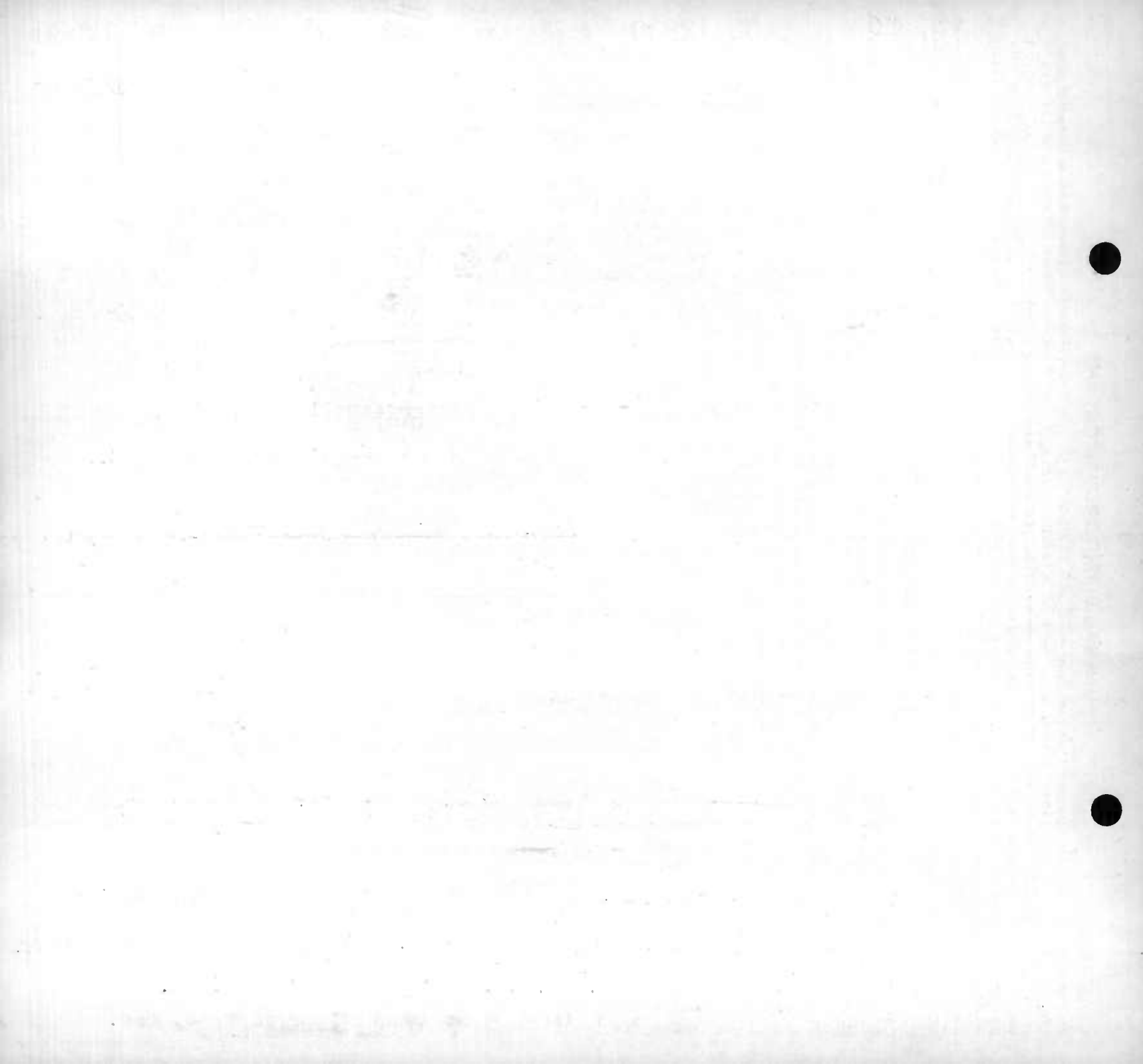




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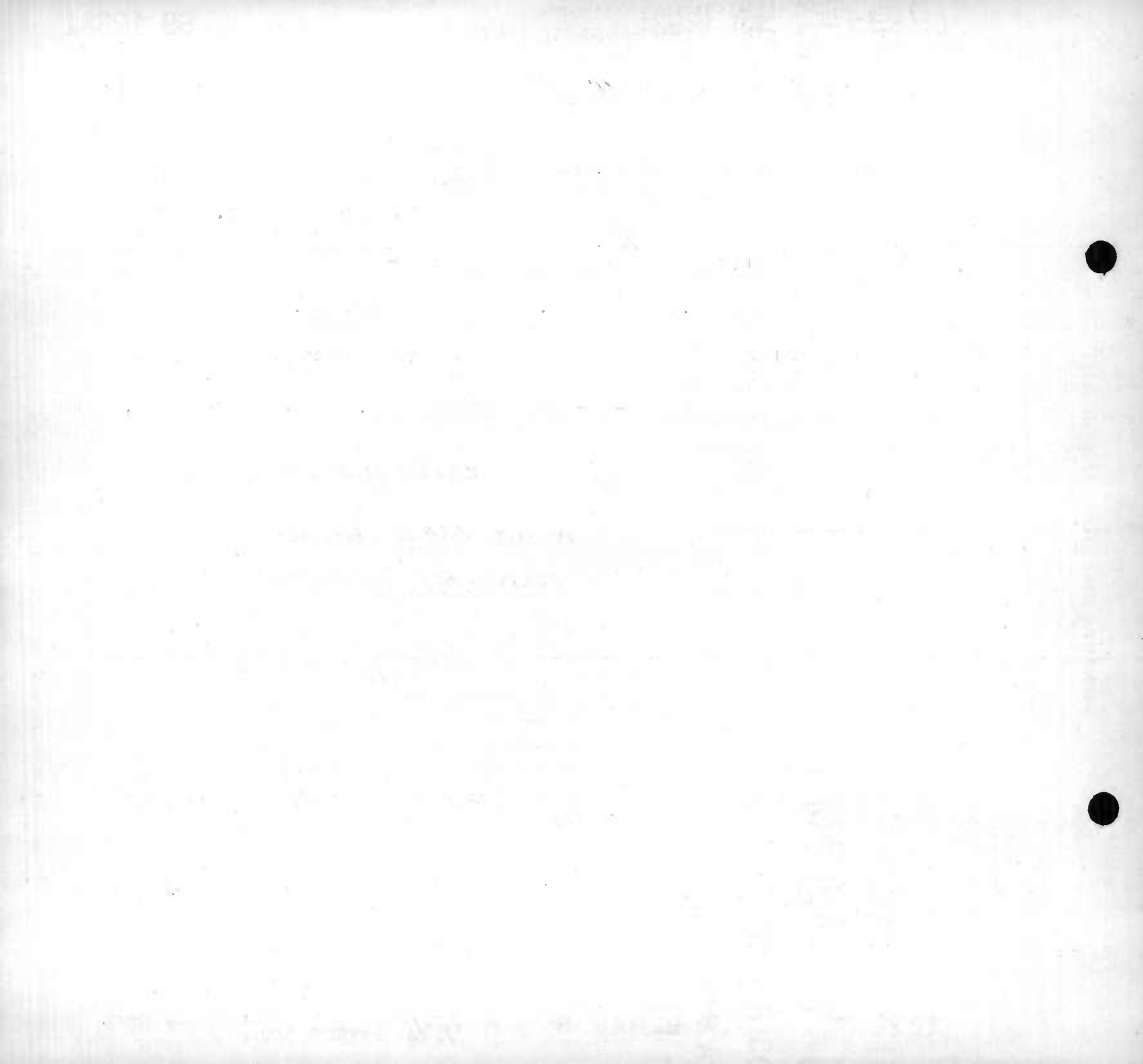
BALTIMORE CITY HEALTH DEPARTMENT				X REG. NO.		69 12630	
<b>R-100</b> <b>69 12630</b> <b>CERTIFICATE OF DEATH</b>							
1. NAME OF DECEASED (Type or Print) <b>Paul Ruby</b>				2. DATE AND HOUR OF DEATH <b>12/21/69</b> <b>10:10 A.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>44 Union Memorial Hospital</b>				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>md.</b> B. COUNTY <b>Harford</b> C. CITY OR TOWN <b>Street</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER <b>Rte. #2 Box 148</b>			
5. SEX <b>M</b>	6. RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8/10/16</b>	9. AGE (In years last birthday) <b>53</b>	If Under 1 Yr. Months: Days: Hours: Min.	If Under 24 Hrs. Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Construction Foreman</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>Baltimore Gas &amp; Electric</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>Edward Ruby</b>				14. MOTHER'S MAIDEN NAME <b>Matilda Boone</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>yes WW 2 - Army</b>			16. SOCIAL SECURITY NO. <b>013-05-4579</b>		17. INFORMANT <b>June Braswell Ruby, wife, above</b>		
18. <b>410.9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>myocardial infarction</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Arteriosclerotic Heart disease</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 hr.</b> <b>3 yr.</b>			
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <b>July 30 1969</b> to <b>December 21 1969</b> , that (I) ( <del>was</del> ) last saw the deceased alive on <b>December 19 1969</b> and that in (my) ( <del>your</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>was</del> ) ( <del>did</del> ) view the body after death.							
23A. SIGNATURE <b>Norman R. Freeman</b>				23B. DATE SIGNED <b>12/21/69</b>			
23C. PHYSICIAN'S NAME (Type) <b>NORMAN R. FREEMAN JR</b>				23D. ADDRESS <b>11W 29th St Baltimore, Md</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12/24/69</b>		24C. NAME OF CEMETERY or CREMATORY <b>Balto. Nat. Cem. Balto</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 23 1969</b>		25B. NAME OF REGISTRAR <b>Robert E. Fisher, Jr.</b>		25C. FUNERAL DIRECTOR <b>Schimmunek Funeral Home, Inc.</b>		ADDRESS <b>3331 Brehms Lane</b>	



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<div style="display: flex; justify-content: space-between;"> <span>W-355</span> <span>69 12631</span> </div>		BALTIMORE CITY HEALTH DEPARTMENT <b>CERTIFICATE OF DEATH</b>		REG. NO. <span style="font-size: 1.2em;">69 12631</span>	
BIRTH NO. _____		1. NAME OF DECEASED <span style="font-size: 1.2em;">Anna</span> (Type or Print) <span style="font-size: 1.2em;">MARIE WEIDENHAM (Weidenham)</span>		2. DATE AND HOUR OF DEATH <span style="font-size: 1.2em;">3 55 pm 12/19/69</span>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION <span style="font-size: 1.2em;">33 JOHN S HOPKINS HOSPITAL</span> (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <span style="font-size: 1.2em;">MARYLAND</span> B. COUNTY <span style="font-size: 1.2em;">2631</span>		C. CITY OR TOWN <span style="font-size: 1.2em;">BALTIMORE</span> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <span style="font-size: 1.2em;">FEMALE</span>		6. RACE <span style="font-size: 1.2em;">WHITE</span>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">Sqaamstress</span>		10B. KIND OF BUSINESS OR INDUSTRY <span style="font-size: 1.2em;">L.Grief Bros.</span>		11. BIRTHPLACE (State or foreign country) <span style="font-size: 1.2em;">Baltimore, Md.</span>	
13. FATHER'S NAME <span style="font-size: 1.2em;">BERNARD PFIEFER</span>		14. MOTHER'S MAIDEN NAME <span style="font-size: 1.2em;">EVA KNUECKER</span>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <span style="font-size: 1.2em;">215-03-7433</span>	
16. SOCIAL SECURITY NO. <span style="font-size: 1.2em;">215-03-7433</span>		17. INFORMANT <span style="font-size: 1.2em;">August F. Weidenham, husband, above</span>		ADDRESS _____	
18. <span style="font-size: 1.2em;">347.91</span> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE <span style="font-size: 1.2em;">CARDIORESPIRATORY ARREST</span> DUE TO, OR AS A CONSEQUENCE OF:  (B) <span style="font-size: 1.2em;">ANOXIC BRAIN DISEASE</span> DUE TO, OR AS A CONSEQUENCE OF:  (C) <span style="font-size: 1.2em;">PULMONARY INFECTION</span>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH _____	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). _____					
19A. DATE OF OPERATION <span style="font-size: 1.2em;">O</span>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED _____		20A. AUTOPSY? (Yes or No) <span style="font-size: 1.2em;">NO</span>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) _____	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) _____		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? _____	
22. I certify that (I) (this hospital) attended the deceased from <span style="font-size: 1.2em;">12/8</span> 19 <span style="font-size: 1.2em;">69</span> to <span style="font-size: 1.2em;">12/19</span> 19 <span style="font-size: 1.2em;">69</span> , that (I) (we) last saw the deceased alive on <span style="font-size: 1.2em;">12/19</span> 19 <span style="font-size: 1.2em;">69</span> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <span style="font-size: 1.2em;">Ralph De Fronzo</span>		23B. DATE SIGNED <span style="font-size: 1.2em;">12/19/69</span>		23C. PHYSICIAN'S NAME (Type) <span style="font-size: 1.2em;">RALPH DEFONZO</span>	
23D. ADDRESS <span style="font-size: 1.2em;">JOHN S HOPKINS HOSPITAL</span>		24A. BURIAL CREMATION, REMOVAL (Specify) <span style="font-size: 1.2em;">Burial</span>		24B. DATE <span style="font-size: 1.2em;">12/23/69</span>	
24C. NAME of CEMETERY or CREMATORY <span style="font-size: 1.2em;">Holy Redeemer Cemetery</span>		24D. LOCATION (City, town, or county) <span style="font-size: 1.2em;">Baltimore, Md.</span>		25A. DATE REC'D BY HEALTH DEPT. <span style="font-size: 1.2em;">DEC 23 1969</span>	
25B. NAME OF REGISTRAR <span style="font-size: 1.2em;">Robert E. Taylor, M.D.</span>		25C. FUNERAL DIRECTOR <span style="font-size: 1.2em;">Schimunek Funeral Home, Inc.</span>		ADDRESS <span style="font-size: 1.2em;">73301 Breams Lane</span>	



FUNERAL DIRECTOR: IMPORTANT

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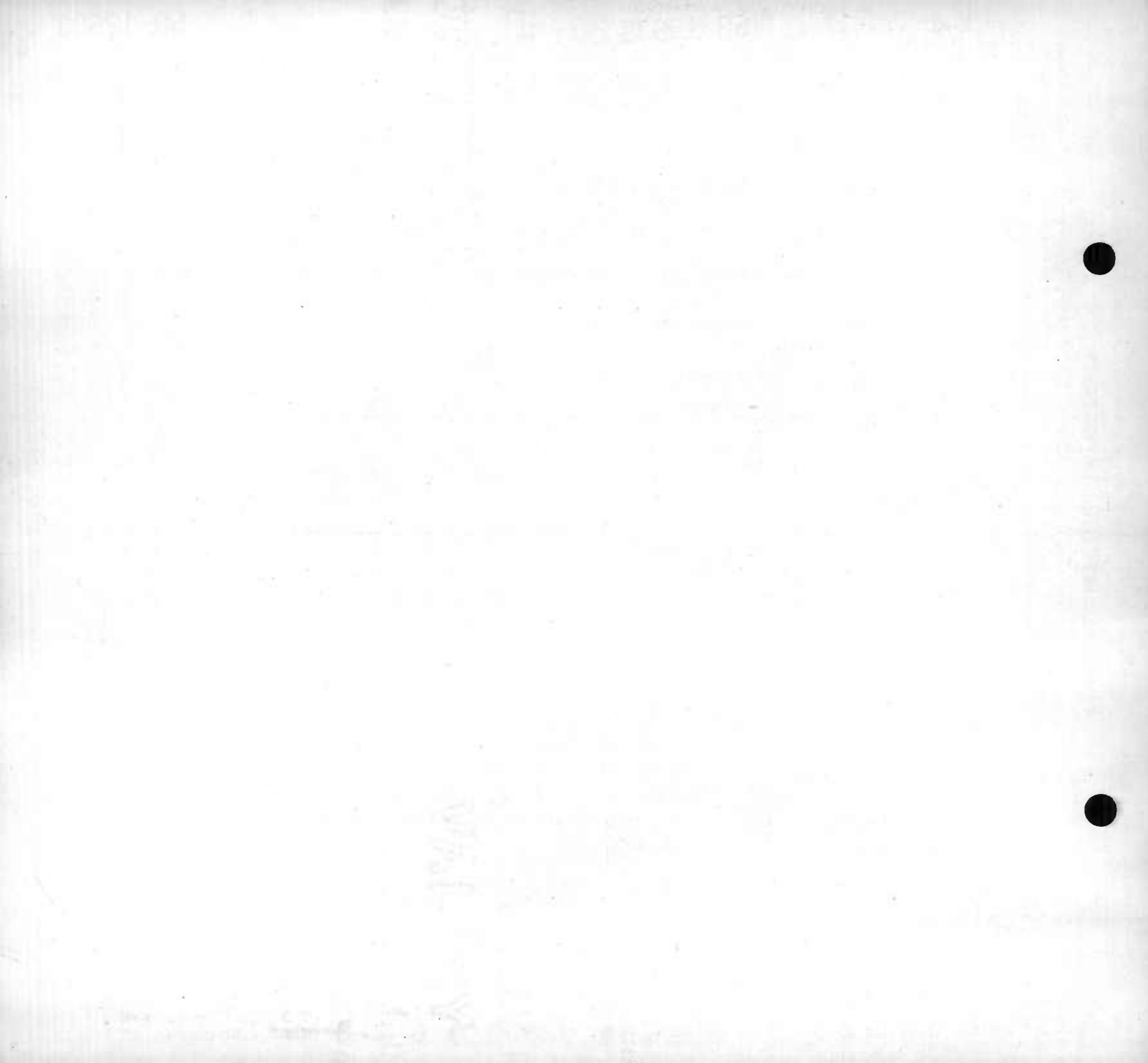
BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <b>69 12632</b>	
S-530 69 12632		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <b>Henry Vernon H. Smith</b>		2. DATE AND HOUR OF DEATH <b>December 20, 1969 11:35 P.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>33 THE JOHNS HOPKINS HOSPITAL</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTIMORE CITY</b> C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>3446 ERDMAN AVENUE 21213</b>	
5. SEX <b>MALE</b>	6. RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4-20-06</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Senior Clerk</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Gas &amp; Elec. Co.</b>	9. AGE (In years lost birthday) <b>63</b>
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>Antoinette Reiber</b>	
13. FATHER'S NAME <b>JOHN SMITH</b>		14. MOTHER'S MAIDEN NAME <b>Antoinette Reiber</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>212-05-7030</b>		16. SOCIAL SECURITY NO. <b>212-05-7030</b>	
17. INFORMANT <b>Thelma Medinger Smith, wife, above</b>		ADDRESS	
18. <b>162.1 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <b>Bronchogenic carcinoma</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. <b>Chronic obstructive pulmonary disease</b> <b>Arteriosclerotic cardiovascular disease</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 years</b> <b>5 years</b> <b>5 years</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION <b>2 NONE</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) <b>YES</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <b>NO</b>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>December 19 19 69</b> to <b>December 20 19 69</b> , that (I) (we) last saw the deceased alive on <b>December 20 19 69</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.			
23A. SIGNATURE <b>James W. Forester, M.D.</b>		23B. DATE SIGNED <b>December 20, 1969</b>	
23C. PHYSICIAN'S NAME (Type) <b>JAMES W. FORESTER</b>		23D. ADDRESS <b>THE JOHNS HOPKINS HOSPITAL</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>12/23/69</b>	24C. NAME OF CEMETERY or CREMATORY <b>Loudon Park</b>	24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 23 1969</b>	25B. NAME OF REGISTRAR <b>Robert E. Farley, M.D.</b>	25C. FUNERAL DIRECTOR <b>Schimunek Funeral Home, Inc.</b>	
		ADDRESS <b>73531 Brehms Lane</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

G-350		69 12633		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 69 12633	
1. NAME OF DECEASED (Type or Print) <b>GOODWIN, GEORGE Edward</b>				2. DATE AND HOUR OF DEATH <b>19 Dec 1969 10:35 A M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>The Johns Hopkins Hospital</b> <b>33</b>				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>2610</b>			
				C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <b>437 N. Clinton Street</b>			
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>8/15/93</b>	9. AGE (In years last birthday) <b>76</b>	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Engineer</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Penna. R. R.</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>John Godwin</b>				14. MOTHER'S MAIDEN NAME <b>Mary A. Morrison</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>yes WW 1 - Navy</b>		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <b>Myrtle Godwin, wife, above</b>			
18. <b>410.3 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) IMMEDIATE CAUSE <b>Pulmonary edema &amp; cardiopulmonary arrest</b> DUE TO, OR AS A CONSEQUENCE OF: (B) <b>myocardial infarction or pulmonary embolus</b> DUE TO, OR AS A CONSEQUENCE OF: (C) <b>ASCVD, ASHD, CAD</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>10 hours</b> <b>10 hours</b> <b>4 years</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				<b>NA</b>			
19A. DATE OF OPERATION <b>NA</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>NA</b>		20A. AUTOPSY? (Yes or No) <b>NO</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>NA</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <b>NA</b>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>NA</b>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>NA</b>			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) <b>NA</b>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> <b>NA</b>		21F. HOW DID INJURY OCCUR? <b>NA</b>			
22. I certify that (I) (this hospital) attended the deceased from <b>9:05 AM 19 Dec, 1969</b> to <b>10:35 AM, 19 Dec 1969</b> , that (I) (we) last saw the deceased alive on <b>10:35 AM 19 Dec 1969</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>John L. Sullivan, M.D.</b>				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>19 Dec 1969</b>	
23C. PHYSICIAN'S NAME (Type) <b>John L. Sullivan, M.D.</b>				23D. ADDRESS <b>The Johns Hopkins Hospital</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12/22/69</b>		24C. NAME OF CEMETERY or CREMATORY <b>Gardens of Faith</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 23 1969</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor, M.D.</b>		25C. FUNERAL DIRECTOR <b>Schimunek Funeral Home, Inc.</b>		ADDRESS <b>63331 Brehms Lane</b>	

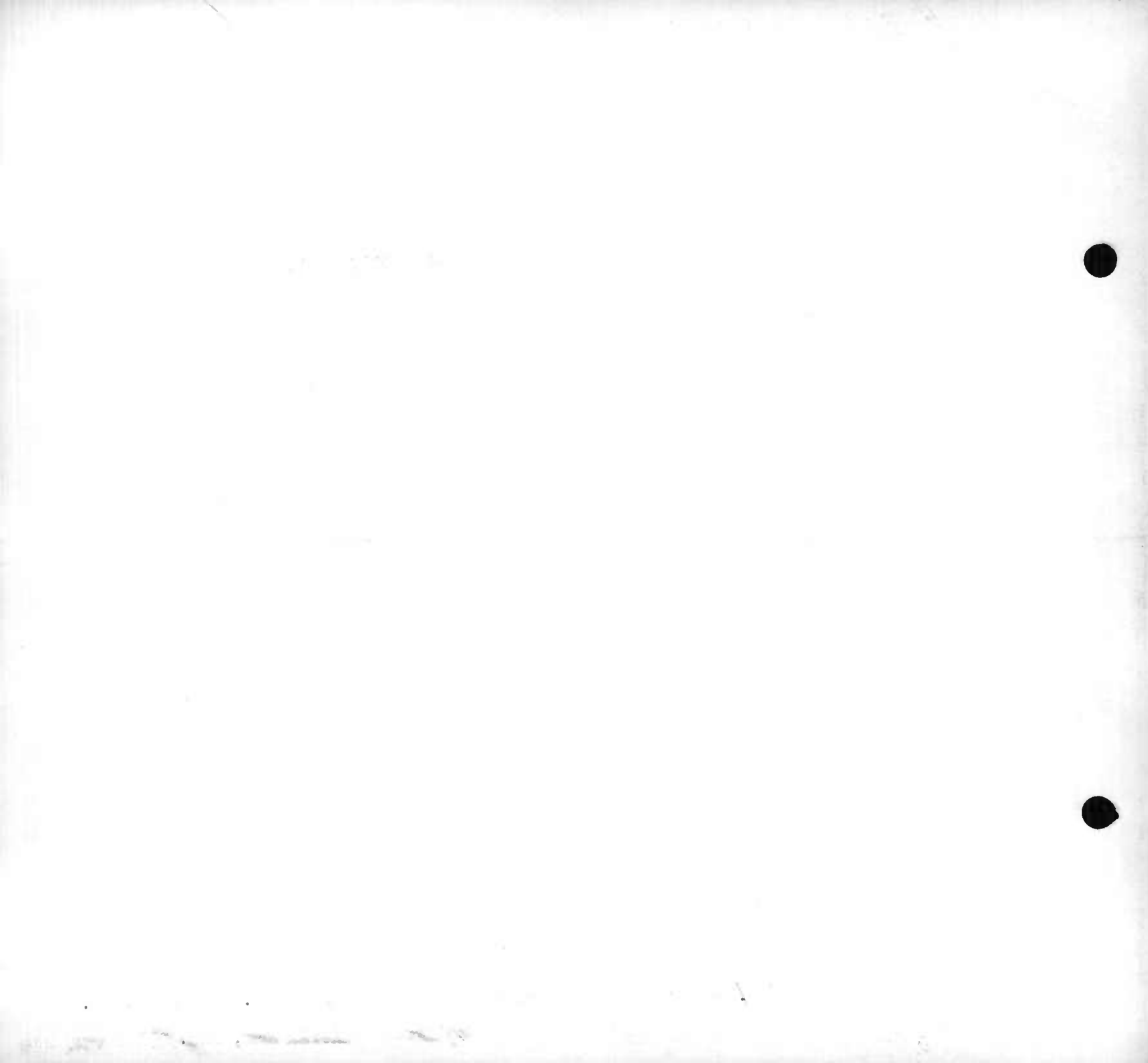




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-362 69 12634		BALTIMORE CITY HEALTH DEPARTMENT <b>CERTIFICATE OF DEATH</b>		REG. NO. 69 12634	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>BUDRES Mrs. Anna MARIE</b>		2. DATE AND HOUR OF DEATH <b>12.18.1969 8:55 P. M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <b>Church Home &amp; Hospital 100 N Broad Way Baltimore Md. 21231</b>		A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b>		C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <b>2806 Ashland Av 05</b>		5. SEX <b>Female</b> 6. RACE <b>W</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <b>8-24-1899</b>		9. AGE (In years last birthday) <b>70</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Homemaker</b>	
11. BIRTHPLACE (State or foreign country) <b>MD. Maryland</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>		13. FATHER'S NAME <b>Andrew Struck</b>	
14. MOTHER'S MAIDEN NAME <b>Theresa Andrews</b>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>214 562708</b>	
17. INFORMANT <b>Charles Budres</b>		ADDRESS <b>Same as above</b>		18. <b>25091</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>ASHD</b> <b>Diabetes mellitus</b> <b>Hypertension</b> <b>Severe atherosclerosis</b>	
19. DATE OF OPERATION <b>0</b>		20. AUTOPSY? (Yes or No) <b>NO</b>		21. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
22. I certify that (H) (this hospital) attended the deceased from <b>4th December 1969</b> to <b>12.18.1969</b> that (I) (we) last saw the deceased alive on <b>12.18.1969</b> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		23A. SIGNATURE <b>Abdus Samad</b>		23B. DATE SIGNED <b>12/18/69</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12/22/1969</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Oak Lawn Cemetery</b>	
24D. LOCATION (City, town, or county) <b>Eastern Ave. Baltimore, Md.</b>		24E. NAME OF REGISTRAR <b>Robert E. Taylor, Md.</b>		24F. FUNERAL DIRECTOR <b>Scimmek Funeral Home, Inc. 3331 Brehms Lane</b>	



FUNERAL DIRECTOR: IMPORTANT

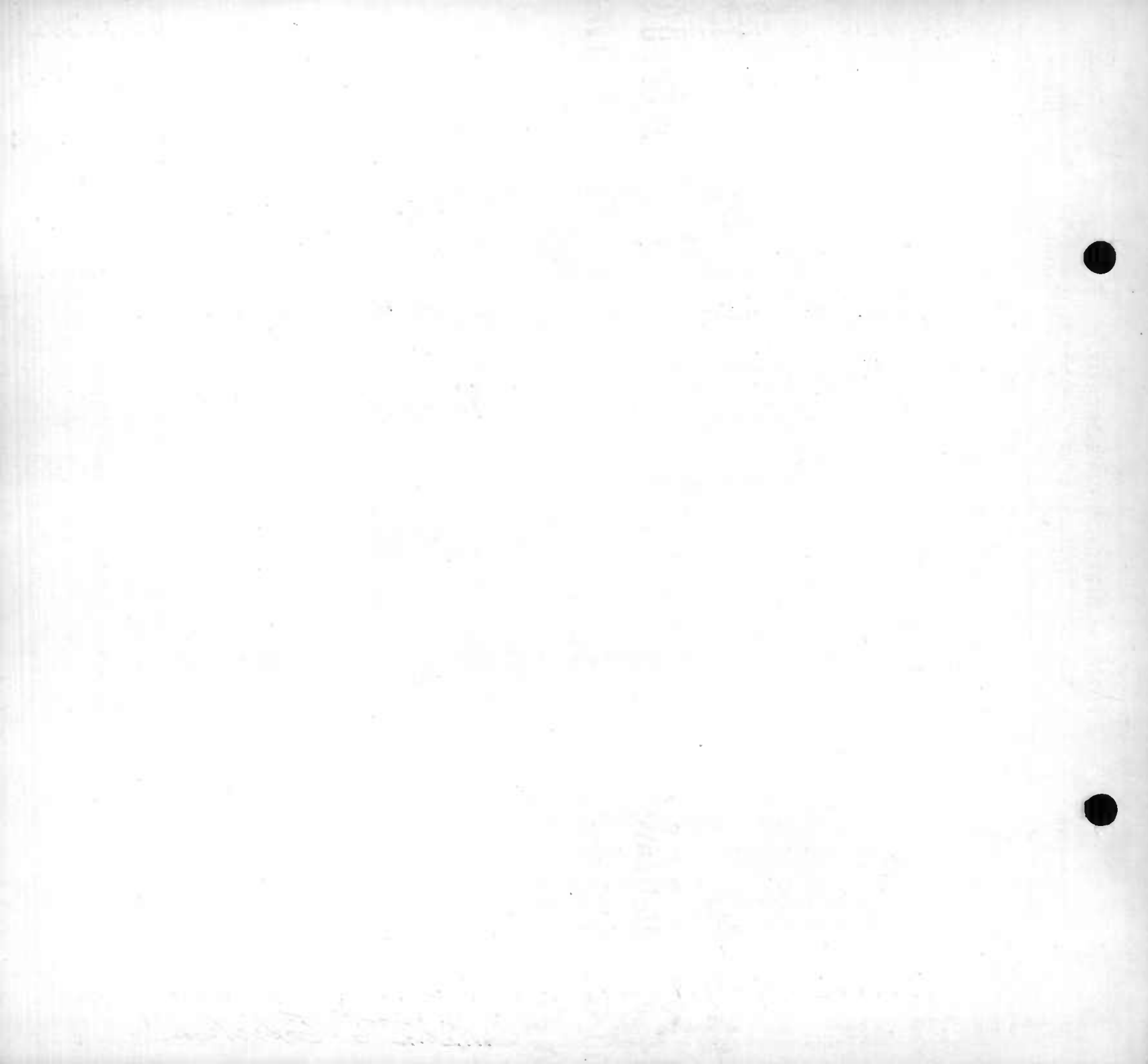
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT  
REG. NO. 69 12635

B-260 69 12635  
**CERTIFICATE OF DEATH**

1. NAME OF DECEASED (Type or Print) <b>BOOKER, John</b>		2. DATE AND HOUR OF DEATH <b>Dec 22, 1969 8:00 A.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>33 The Johns Hopkins Hospital</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>501</b> C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>303 N. Central Avenue</b>	
5. SEX <b>Male</b>	6. RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3/01/06</b>
9. AGE (In years last birthday) <b>63</b>		If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>STEEL Worker</b>		10B. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Cumberland, Va.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Ellis Booker</b>		14. MOTHER'S MAIDEN NAME <b>Patty West</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.	17. INFORMANT <b>Brouder Booker</b>
18. CAUSE OF DEATH I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Aspiration</b> II. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Esophageal carcinoma</b> III. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 hours</b> <b>1 year</b>	
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) <b>Yes</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>No</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from <b>Dec 1 1969</b> to <b>Dec 22 1969</b> , that (1) (we) last saw the deceased alive on <b>Dec 21 1969</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <b>Thomas R. Griggs, M.D.</b>		23B. DATE SIGNED <b>Dec 22 69</b>	
23C. PHYSICIAN'S NAME (Type) <b>Thomas R. Griggs, M.D.</b>		23D. ADDRESS <b>The Johns Hopkins Hospital</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>12/27/69</b>	24C. NAME OF CEMETERY or CREMATORY <b>Arbutus Mem. Park</b>	24D. LOCATION (City, town, or county) (State) <b>Arbutus, Md.</b>
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 23 1969</b>		25B. NAME OF REGISTRAR <b>Robert E. Bailey</b>	
25C. FUNERAL DIRECTOR <b>Milton E. Erickson</b>		ADDRESS	

VS 150-REV. 1/1/68



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

V-250		69 12636		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 69 12636	
BIRTH NO.				1. NAME OF DECEASED (Type or Print)			
2. DATE AND HOUR OF DEATH				3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			
12/17/69 9:15 A. M.				VAUGHN, Clarence			
4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)				5. SEX			
A. STATE Maryland				Male			
B. COUNTY 604				6. RACE			
C. CITY OR TOWN Baltimore				Negro			
D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>			
E. STREET AND NUMBER 227 N. Wolfe Street				WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				8. DATE OF BIRTH			
33 The Johns Hopkins Hospital				3/19/05			
9. AGE (In years last birthday) 64				10. A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			
11. BIRTHPLACE (State or foreign country) Va.				12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Unknown				Unknown			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
No				17. INFORMANT			
Ethel Vaughn				ADDRESS			
18. 427.21 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH			
(This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.)				① Cardiorespiratory Arrest.			
ANTECEDENT CAUSES				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				② Ascitis			
II				(B) DUE TO, OR AS A CONSEQUENCE OF:			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				③ Mitotic process of			
19A. DATE OF OPERATION				20A. AUTOPSY? (Yes or No)			
2				Yes			
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? NO			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				21D. TIME OF INJURY (Approx.)			
21E. INJURY OCCURRED				21F. HOW DID INJURY OCCUR?			
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>							
22. I certify that (X) (this hospital) attended the deceased from December 9 <sup>th</sup> 19 69 to December 17 <sup>th</sup> 19 69, that (X) (we) lost saw the deceased alive on December 17 <sup>th</sup> 19 69 and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
Francisco Tejada				December 17 <sup>th</sup> 19 69			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
Francisco Tejada				Johns Hopkins Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify)				24B. DATE			
Burial Dec 20/69				Arbutus Mem Park			
24C. NAME OF CEMETERY or CREMATORY				24D. LOCATION (City, town, or county) (State)			
Arbutus, Md.							
25A. DATE REC'D BY HEALTH DEPT.				25B. NAME OF REGISTRAR			
DEC 23 1969 Robert E. Tejada				25C. FUNERAL DIRECTOR			
				25D. ADDRESS			
				1129 N. Caroline St			

Letter from Johns Hopkins Hospital  
giving marital status as "Married"  
1-5-1970 M.H

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		69 12637	
1. NAME OF DECEASED (Type or Print)		COFRAN		REG. NO.	
LEONARD, IRVIN CLARENCE		DECEMBER 20, 1969		1:15 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		A. STATE	
IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS IN LOCATION OF DEATH		B. COUNTY		21229	
ST AGNES HOSPITAL		MARYLAND		C. CITY OR TOWN	
CATON & WILKENS AVENUES		BALTIMORE		D. INSIDE CITY LIMITS?	
BALTIMORE, MARYLAND 21229		4228 ELDONE ROAD		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX		6. RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	
MALE		WHITE		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH	
OFFICE CLERK		STEEL		04/20/92	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		9. AGE (In years lost birthday)	
SAMUEL LEONARD		SARA X Sarah A. Hurtle		XX 77	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		11. BIRTHPLACE (State or foreign country)	
Yes		W W I		MARYLAND	
		217-14-2999		12. CITIZEN OF WHAT COUNTRY?	
				U.S.A.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES		(B) DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) _____			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		Decadental Discrepancies			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
2				YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (X) (this hospital) attended the deceased from DECEMBER 16 19 69 to DECEMBER 20 19 69 that (X) (we) last saw the deceased alive on DECEMBER 20 19 69 and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (not) view the body after death.					
23A. SIGNATURE		23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type)	
		12 20 69		ADOLFO ALONSO M.D.	
23D. ADDRESS		23E. ADDRESS		23F. ADDRESS	
CATON & WILKENS AVES. BALTO., MD. 21229		CATON & WILKENS AVES. BALTO., MD. 21229		CATON & WILKENS AVES. BALTO., MD. 21229	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		12-22-69		Western Cemetery	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
DEC 23 1969		Robert E. Taylor, M.D.		Howard H. Hubbard	
				ADDRESS	
				4107 Wilkens Ave. 21229	

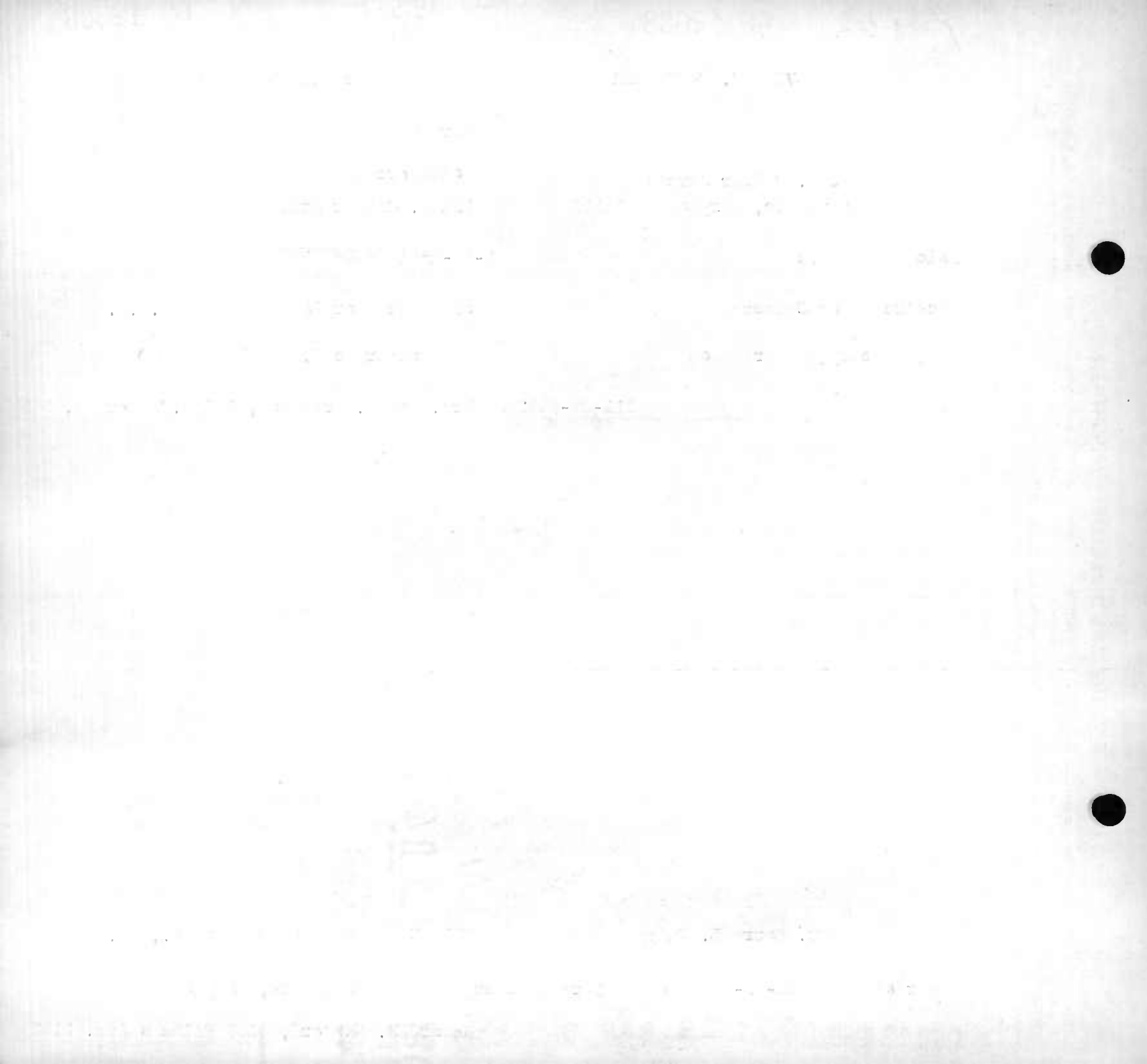
VS153



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

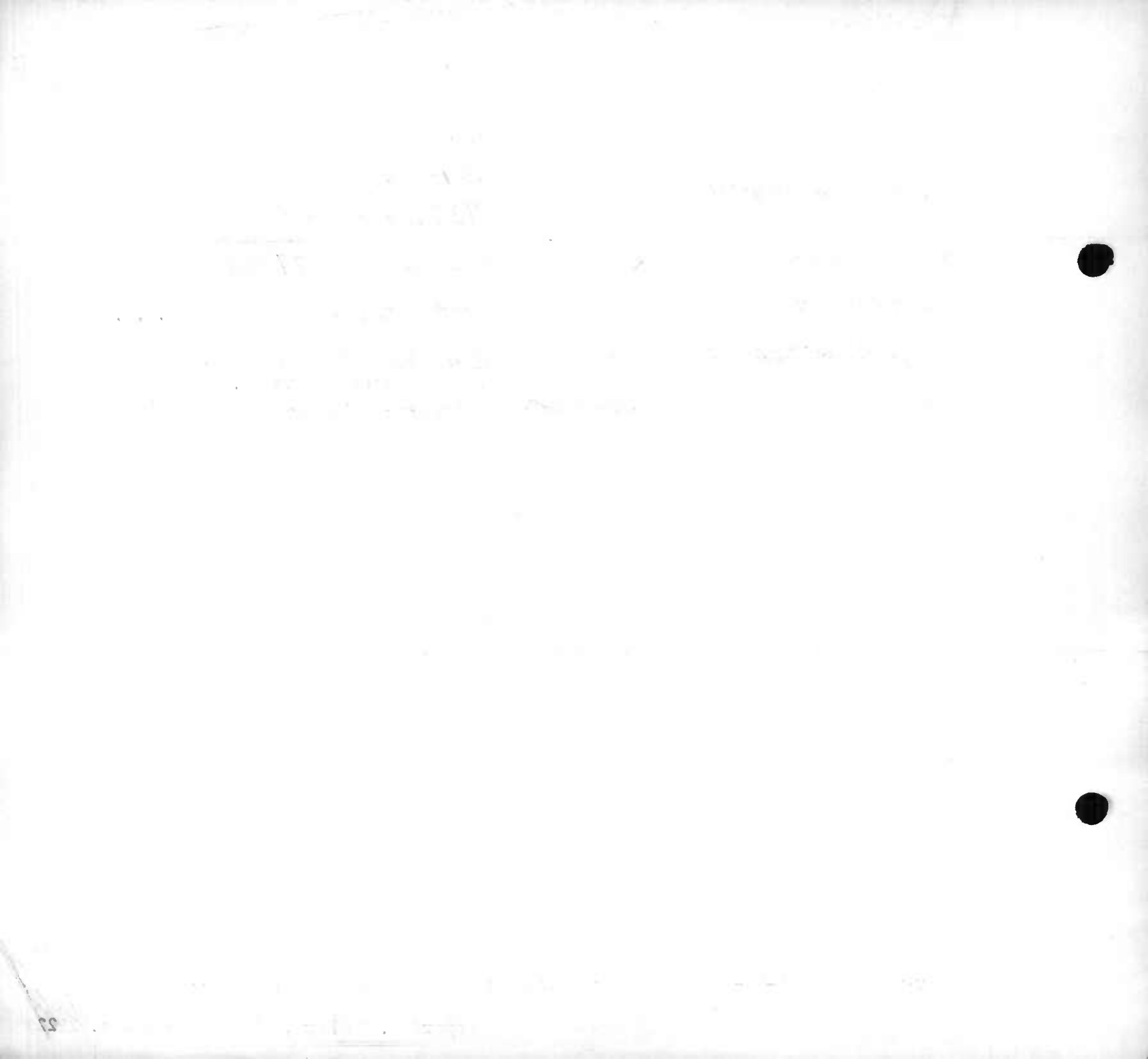
BALTIMORE CITY HEALTH DEPARTMENT		69 12638		69 12638	
BIRTH NO. <span style="font-size: 2em;">B-652</span>		69 12638		REG. NO.	
1. NAME OF DECEASED (Type or Print) <b>ALVIN G. BRINKMAN</b>			2. DATE AND HOUR OF DEATH <b>December 20, 1969</b> <span style="float: right;">10:00 P. M.</span>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION  <b>00 231 S. Gilmore Street Baltimore, Maryland 21223</b>			A. STATE <b>Maryland</b> B. COUNTY <b>1902</b>		
			C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER <b>231 S. Gilmore Street</b>		
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2-13-1891</b>	9. AGE (in years lost birthday) <b>78</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Meat Cutter</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Henry Brinkman</b>			
14. MOTHER'S MAIDEN NAME <b>Katherine W. (Unknown)</b>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>			
16. SOCIAL SECURITY NO. <b>212-03-9432 A</b>		17. INFORMANT ADDRESS <b>Mrs. Ida S. Brinkman, 231 S. Gilmore St. 21223</b>			
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>162.1 I Bronchogenic Carcinoma</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) <b>Arteriosclerotic Cardio Vasc. Disease.</b> (C) _____			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>8-5-1969</b> to <b>12-20-1969</b> , that (I) (we) last saw the deceased alive on <b>12-20-1969</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Harry L. Knipp, M.D.</b>				23B. DATE SIGNED <b>12-22-69</b>	
23C. PHYSICIAN'S NAME (Type) <b>Dr. Harry L. Knipp</b>				23D. ADDRESS <b>4116 Edmondson Avenue, Balto., Md. 21229</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12-23-69</b>		24C. NAME OF CEMETERY or CREMATORY <b>Loudon Park Cemetery</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>					
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR <b>Robert E. Fisher, M.D.</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Howard H. Hubbard, 4107 Wilkens Ave. 21229</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

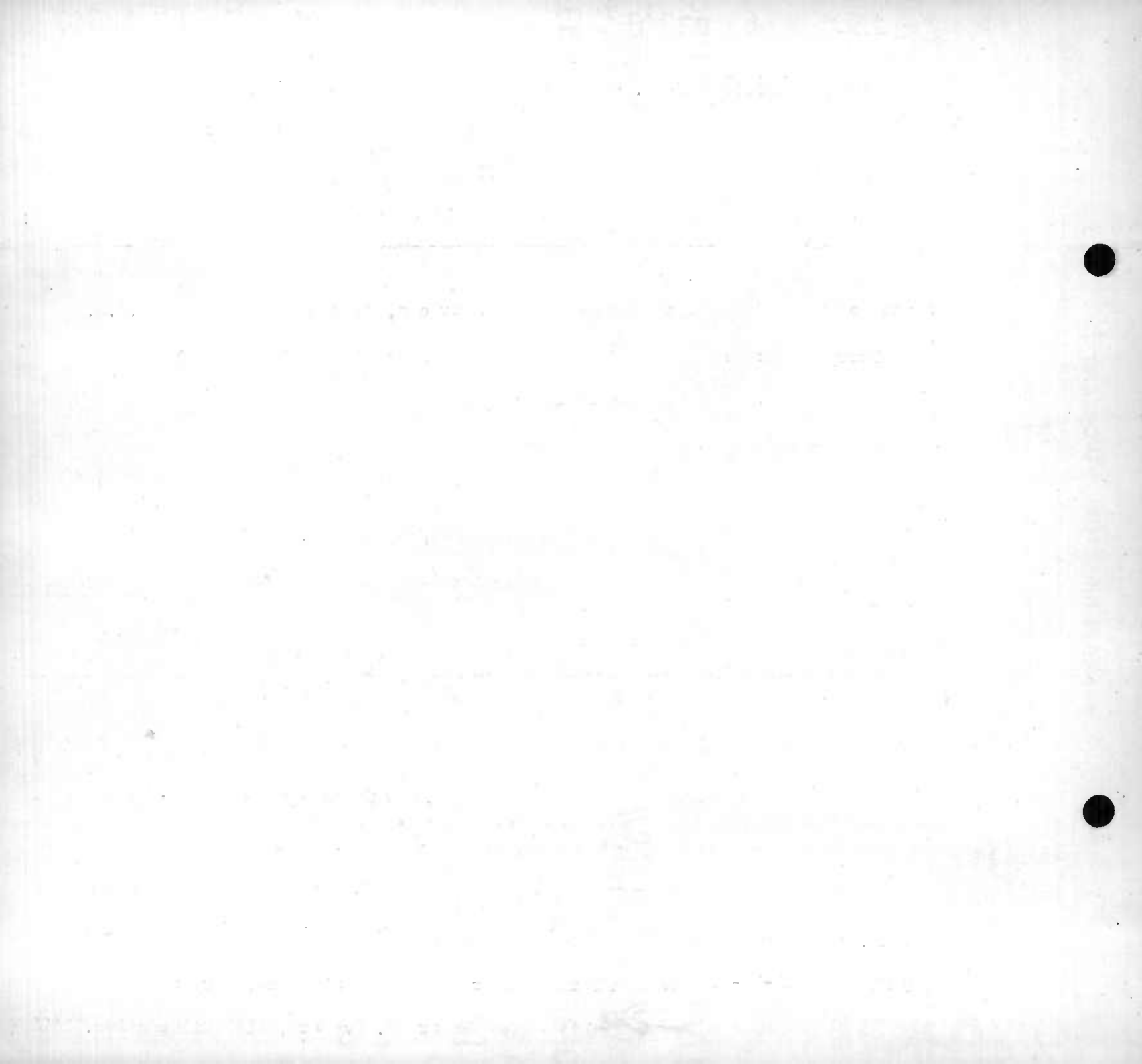
Z-520		69 12639		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 69 12639	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) <u>Zink, Walter</u>			
2. DATE AND HOUR OF DEATH <u>12/21/69</u> <u>1</u> <u>30</u> <u>A</u> M.							
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>2541</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>Bon Secours Hospital</u>				C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				E. STREET AND NUMBER <u>737 Bethnal Rd.</u>			
5. SEX <u>Male</u>	6. RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/5/92</u>	9. AGE (In years last birthday) <u>77</u>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Tailor</u>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Lithuania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Joseph Zayenkauskas</u>				14. MOTHER'S MAIDEN NAME <u>Esther Zelinski</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO. <u>215-07-0478</u>		17. INFORMANT <u>Miss Dolores H. Zink</u> ADDRESS <u>Chart 737 Bethnal Road 21229</u>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <u>Respiratory failure.</u> <u>C.A. Lung?</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>C.V.A. ?</u>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>4 months.</u>			
MEDICAL CERTIFICATION							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <u>12/19/1969</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input checked="" type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>at Home.</u>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) <u>Dec. 8, 1969.</u>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? <u>Fell down</u>			
22. I certify that (I) (this hospital) attended the deceased from <u>12, 10</u> 19 <u>69</u> to <u>12, 21</u> 19 <u>69</u> that (I) (we) last saw the deceased alive on <u>12, 20</u> 19 <u>69</u> and that (n) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Varah Vorasubin, M.D.</u>				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>12, 21, 1969.</u>	
23C. PHYSICIAN'S NAME (Type) <u>VARAH VORASUBIN, M.D.</u>				23D. ADDRESS <u>Bon Secours Hospital, Balto, Md.</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>12-24-69</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>DEC 23 1969</u>		25B. NAME OF REGISTRAR <u>Robert E. Fisher, M.D.</u>		25C. FUNERAL DIRECTOR <u>Howard H. Hubbard</u>		ADDRESS <u>4107 Wilkens Ave. 21229</u>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.	69 12640
<b>BIRTH NO.</b> <b>1. NAME OF DECEASED</b> (Type or Print) <u>HENRY <del>XXXXXXXXXX</del> A. BEACHAM</u>		<b>2. DATE AND HOUR OF DEATH</b> <u>12-21-69</u> <u>10</u> <u>30</u> <u>A</u> M.			
<b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b>  <b>FULL NAME OF HOSPITAL OR INSTITUTION</b> (If not in hospital or institution, give street address or location) <u>Bolton Hill Nursing Home</u>		<b>4. USUAL RESIDENCE</b> (Where deceased lived, if institution: residence before admission) A. STATE <u>Mo.</u> B. COUNTY <u>Baltimore</u> <b>C. CITY OR TOWN</b> <u>Lansdowne</u> <b>D. INSIDE CITY LIMITS?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <b>E. STREET AND NUMBER</b> <u>3119 BERO ROAD</u>			
<b>5. SEX</b> <u>M</u>	<b>6. RACE</b> <u>W</u>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>1-30-99</u>		<b>9. AGE</b> (In years last birthday) <u>70</u>
<b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Maintenance Man</u>		<b>10B. KIND OF BUSINESS OR INDUSTRY</b> <u>Westinghouse</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Americus, Georgia</u>	
<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>		<b>13. FATHER'S NAME</b> <u>Perry Beacham</u>			
<b>14. MOTHER'S MAIDEN NAME</b> <u>Josephine (Unknown)</u>		<b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>			
<b>16. SOCIAL SECURITY NO.</b> <u>215-18-1506</u>		<b>17. INFORMANT</b> <u>Bolton Hill Nursing Home</u>			
<b>18. ADDRESS</b> <u>1400 John St.</u>		<b>19. CAUSE OF DEATH</b> <b>I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <u>Cerebral thrombosis</u> <b>ANTCEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>(A) IMMEDIATE CAUSE</b> <u>Cerebral thrombosis</u> <b>(B) DISEASE OR CONDITION</b> <u>Arteriosclerosis C.V. disease</u> <b>(C) DISEASE OR CONDITION</b> <u>Diabetes mellitus</u>			
<b>II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).</b>		<b>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</b> <u>years</u> <u>years</u> <u>years</u>			
<b>19A. DATE OF OPERATION</b> <u>0</u>		<b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b>		<b>20A. AUTOPSY?</b> (Yes or No)	
<b>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</b>		<b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner) <input type="checkbox"/>			
<b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		<b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)		<b>21D. TIME OF INJURY</b> (Month) (Day) (Year) (Hour)	
<b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		<b>21F. HOW DID INJURY OCCUR?</b>			
<b>22. I certify that (I) (this hospital) attended the deceased from</b> <u>12/16</u> <u>19 69</u> <b>to</b> <u>12/21</u> <u>19 69</u> , <b>that (I) (we) lost</b> <u>saw the deceased alive on</u> <u>12/21</u> <u>19 69</u> <b>and that in (my) (our) opinion death occurred on the date</b> <u>12/21</u> <u>19 69</u> <b>and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</b>					
<b>23A. SIGNATURE</b> <u>Alan Macht</u>		<b>23B. DATE SIGNED</b> <u>12/21/69</u>		<b>23C. PHYSICIAN'S NAME</b> (Type) <u>ALLAN H. MACHT MD</u>	
<b>23D. ADDRESS</b> <u>2 E Real St Baltimore</u>		<b>24A. BURIAL CREMATION, REMOVAL (Specify)</b> <u>Burial</u>			
<b>24B. DATE</b> <u>12-24-69</u>		<b>24C. NAME OF CEMETERY or CREMATORY</b> <u>Loudon Park Cemetery</u>		<b>24D. LOCATION</b> (City, town, or county) (State) <u>Baltimore, Maryland</u>	
<b>25A. DATE REC'D BY HEALTH DEPT.</b> <u>DEC 23 1969</u>		<b>25B. NAME OF REGISTRAR</b> <u>Robert E. Taylor MD</u>		<b>25C. FUNERAL DIRECTOR</b> <u>Howard H. Hubbard</u>	
<b>25D. ADDRESS</b> <u>4107 Wilkens Ave. 21229</u>					



F-200

69 12641

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

69 12641

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>E.W. FREDERICK FOOS</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>CITY HOSPITAL (DOA)</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>December 20, 1969 10:20 P.</b>	
5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b>		6. SEX <b>Male</b> 7. RACE <b>White</b> 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH <b>1-2-1915</b> 10. AGE (In years lost birthday) <b>54</b> If Under 1 Yr. II Under 24 Hrs. Months Days Hours Min.		C. CITY OR TOWN <b>Deer Park</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b> 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		E. STREET AND NUMBER <b>6727 Yataruba Drive</b>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Mechanic</b>		14B. KIND OF BUSINESS OR INDUSTRY <b>Cleaners Hanger Co.</b>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		17. SOCIAL SECURITY NO. <b>215-10-7873</b>	
18. INFORMANT ADDRESS <b>Mrs. Margaret F. Foos, 6727 Yataruba Dr. 21207</b>		13. FATHER'S NAME <b>Frederick E.W. Foos</b>	
19. <b>472.4</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Arteriosclerotic Cardiovascular Disease</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
		(B) DUE TO, OR AS A CONSEQUENCE OF:	
		(C) DUE TO, OR AS A CONSEQUENCE OF:	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
20A. DATE OF OPERATION <b>2</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?		21. AUTOPSY? (Yes or No) <b>yes</b>	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Isidore Mihalakis, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		DATE SIGNED <b>12/21/69</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12-24-69</b>	
24C. NAME of CEMETERY or CREMATORY <b>Loudon Park Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 23 1969</b>		25B. NAME OF REGISTRAR <b>Robert E. Fisher, M.D.</b>	
25C. FUNERAL DIRECTOR <b>Howard H. Hubbard, 4107 Wilkens Ave. 21229</b>		ADDRESS	

ADDITIONAL BOARD



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

W-100		69 12642		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 69 12642	
BIRTH NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>WEBB RICHARD</b>				2. DATE AND HOUR OF DEATH <b>December 14 9.15 P.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>44 Union Memorial Hospital</b>				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>905</b> C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>800 HOMESTEAD STREET</b>			
5. SEX <b>MALE</b>	6. RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2-16-1886</b>	9. AGE (In years last birthday) <b>83</b>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>LAMPGLASSER</b>		
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				
13. FATHER'S NAME <b>RICHARD WEBB</b>				14. MOTHER'S MAIDEN NAME <b>ELLA CARY</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <b>respiratory failure due to severe</b>	
18. <b>491X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Emphysema of lung</b>				CAUSE OF DEATH <b>severe</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>12/10/69</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Bronchitis severe</b>				(B) DUE TO, OR AS A CONSEQUENCE OF: <b>12/14/69</b>			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>YES</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>December 10 1969</b> to <b>December 14 1969</b> that (I) (we) last saw the deceased alive on <b>December 14 1969</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Miguel Karacushansky M.D.</b>				23B. DATE SIGNED <b>December 14, 1969</b>			
23C. PHYSICIAN'S NAME (Type) <b>Miguel KARACUSHANSKY M.D.</b>				23D. ADDRESS <b>Union Memorial Hospital</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>12-17-69</b>		24C. NAME OF CEMETERY OR CREMATORY <b>GLEN HAVEN MEM. PK.</b>		24D. LOCATION (City, town, or county) (State) <b>GLEN BURNIE, MD.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 23 1969</b>		25B. NAME OF REGISTRAR <b>Robert E. Jaber, M.D.</b>		25C. FUNERAL DIRECTOR <b>Wm. J. TIGNER &amp; SONS</b>		ADDRESS <b>BALD. MD.</b>	

Miss Memorial Hospital

WIFE WHITE

MARYLAND

227

Miss Memorial Hospital  
Wife White  
Maryland  
227

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 69 12643	
H-540		69 12643		CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>MARY ANNA HAMILL</b>		2. DATE AND HOUR OF DEATH <b>DECEMBER 16, 1969 9: P. M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>BALTO.</b>		5. CITY OR TOWN <b>1</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION <b>90 HAVEN NURSING HOME</b> <b>3939 PENHURST AVE.</b>		E. STREET AND NUMBER <b>209 RIVERTHORNE RD</b>			
5. SEX <b>FEMALE</b>	6. RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JAN. 21, 1886</b>	9. AGE (In years lost birthday) <b>83</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED HOUSEWORK AT HOME</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>BALTO.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>JOHN PLETKA</b>		14. MOTHER'S MAIDEN NAME <b>ANNA BASOVA</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>21-24-5971</b>		17. INFORMANT <b>FAMILY</b>	
18. <b>2509 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>8 - infarction of large</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>marked arteriosclerosis</b> (B) DUE TO, OR AS A CONSEQUENCE OF: <b>Diabetes</b> (C) _____		19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>June 1967</b> to <b>Dec 17 1969</b> , that (I) (we) last saw the deceased alive on <b>Dec 14 1969</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death.					
23A. SIGNATURE <b>Thomas E. Abbott</b> OEGREE		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) <b>Thomas E. Abbott</b> OEGREE		23D. ADDRESS <b>4509 Liberty Heights Rd</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>	24B. DATE <b>12-20-69</b>	24C. NAME OF CEMETERY or CREMATORY <b>MOST HOLY REDEEMER</b>		24D. LOCATION (City, town, or county) (State) <b>BALTO., Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 23 1969</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR <b>John Shalton Conklin</b>	
				ADDRESS <b>5444 BELAIR RD</b>	

Dear Sir,

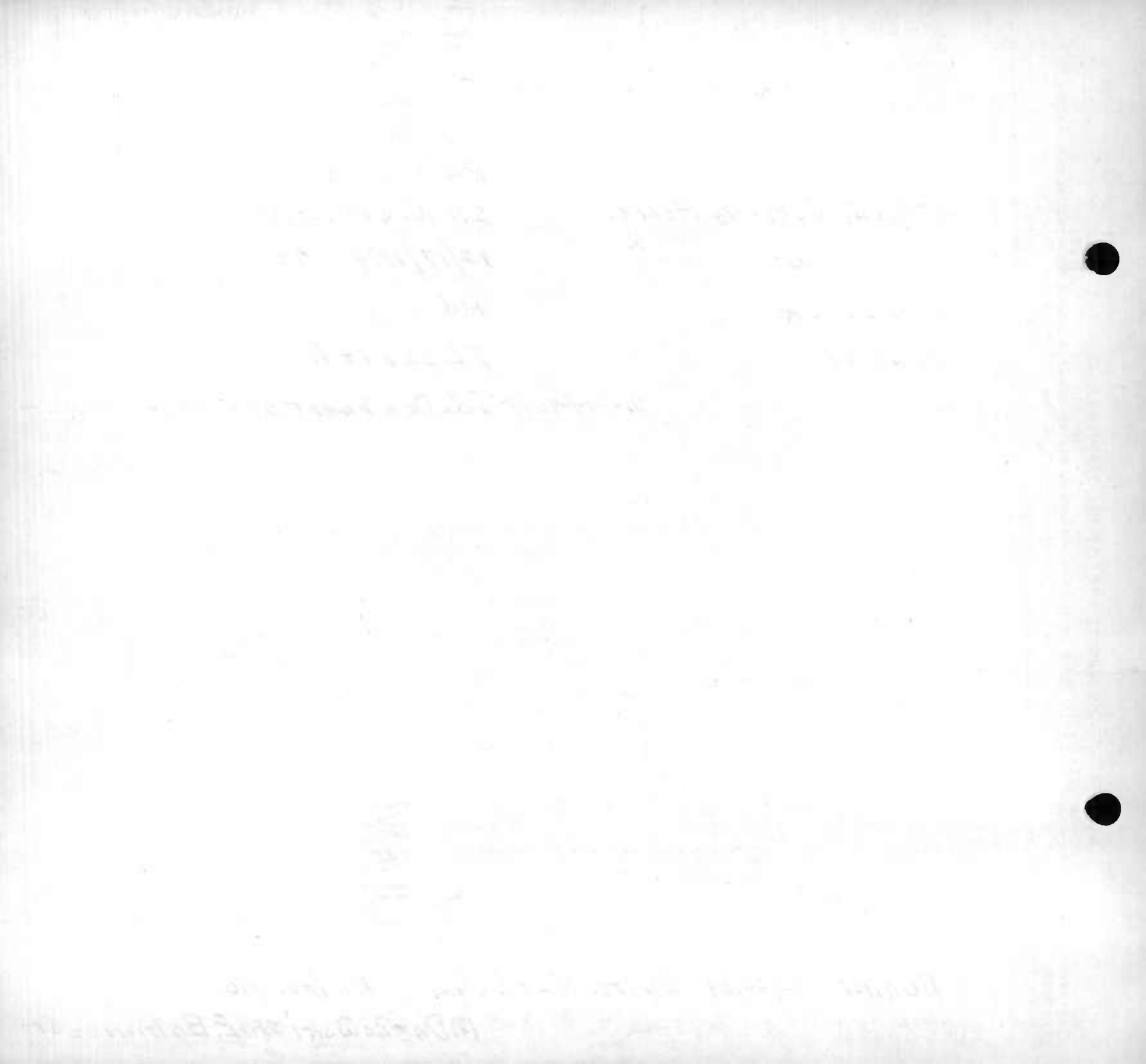
Received from Mr. A. H. Adams  
the sum of \$100.00  
for the family of Mr. Adams

Yours very truly,  
J. H. Adams

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

D-563 69 12644		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 69 12644	
CERTIFICATE OF DEATH					
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
John W. DENHARDT		DEC. 20, 1969		2:00 A. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			A. STATE B. COUNTY		
MT. SINAI NURSING HOME			Md. 601		
			C. CITY OR TOWN		D. INSIDE CITY LIMITS?
			BALTIMORE		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER		
			211 N. STREEPER ST.		
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
M	W	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	12/17/1894	75	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
MECHANICK				Md.	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
Charles			Elizabeth		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
WW-1		214-14-9078		Ida DENHARDT 211 N. STREEPER ST.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			CAUSE OF DEATH		
492X I					
(This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.)			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		
			Resp. insufficiency		
ANTECEDENT CAUSES			(B) DUE TO, OR AS A CONSEQUENCE OF:		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			Pulmonary emphysema, years.		
			(C) years.		
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
Chronic brain syndrome years.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
				NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (the hospital) attended the deceased from 12/5/69 19 to 12/20/69 19, that (I) (we) last saw the deceased alive on 12/5/69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE			23B. DATE SIGNED		
Morton M. Mower M.D.			12/22/69		
23C. PHYSICIAN'S NAME (Type)			23D. ADDRESS		
MORTON M. MOWER M.D.			200 W. Collyer St. Balto. Md.		
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		12/24/69		Balto. Natl. Cem.	
		24D. LOCATION (City, town, or county)		(State)	
		Balto. Md.			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
DEC 23 1969		Robert E. Jelen, M.D.		D. D. BROWSKI 2818 E. Baltimore St.	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				69 12645		REG. NO. 69 12645	
BIRTH NO. <u>C-430</u>				69 12645			
1. NAME OF DECEASED (Type or Print) <u>CLAUD FANNIE</u>				2. DATE AND HOUR OF DEATH <u>12-18-69 2:30 A.M.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>SINAI HOSPITAL OF BALTO</u>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE <u>MARYLAND</u>		B. COUNTY <u>1506</u>	
				C. CITY OR TOWN <u>BALTIMORE</u>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <u>2019 DUKELAND ST. #16</u>			
5. SEX <u>F</u>	6. RACE <u>N</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3-8-21</u>	9. AGE (In years last birthday) <u>48</u>	10. Under 1 Yr. Months: Days: Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cook</u>				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>VIRGINIA</u>	
12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME <u>Pete Fitchett</u>				14. MOTHER'S MAIDEN NAME <u>Mattie Ames</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>224-01-3681</u>		17. INFORMANT <u>Joseph Claud Same</u>	
18. <u>428X1 + 250.9</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>CARDIAC ARREST</u> <u>MINUTES</u>		(B) <u>MIOCARDIAL INSUFAC.</u> DUE TO, OR AS A CONSEQUENCE OF: <u>MONTHS</u>	
				(C) _____			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>OBESITY-DIAB. MELL.</u>				<u>YEARS</u>			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>12-13 1969</u> to <u>12-18 1969</u> that (I) (we) last saw the deceased alive on <u>12-17 1969</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Halper M.D.</u>				23B. DATE SIGNED <u>12-18-69</u>			
23C. PHYSICIAN'S NAME (Type) <u>CARLOS S. VALLEJO M.D.</u>				23D. ADDRESS <u>SINAI HOSPITAL OF BALTO</u>			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <u>12-21-69</u>		24C. NAME of CEMETERY or CREMATORY <u>Chapside East</u>		24D. LOCATION (City, town, or county) (State) <u>Chapside Virginia</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>DEC 23 1969</u>		25B. NAME OF REGISTRAR <u>Robert E. Fisher, M.D.</u>		25C. FUNERAL DIRECTOR <u>Washington Phillips 1727 N. Mount St.</u>		ADDRESS	





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="font-size: 1.2em;">69 12646</span>	
S-160		69 12646		CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>Mary Schaeffer</u>			
2. DATE AND HOUR OF DEATH <u>12/20/69</u> <u>5:55 PM</u>		M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>HOUSE OF THE PINES CONV. HOME</u> <u>90 BELAIR RD</u>		A. STATE <u>MARYLAND</u>		B. COUNTY <u>604</u>	
C. CITY OR TOWN <u>BALTIMORE</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
E. STREET AND NUMBER <u>105 N. WOLFE ST.</u>					
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-18-1890</u>	9. AGE (In years last birthday) <u>79</u>	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>THOMAS DOBRY</u>			
14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>			
16. SOCIAL SECURITY NO.		17. INFORMANT <u>JOSEPHINE BAGINSKI 105 N. WOLFE ST.</u>			
18. CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>4-10-91</u>		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Congestive Heart Failure</u>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF: <u>Acute Myocardial Infarction</u>		<u>72 hrs.</u>	
(C) <u>Arteriosclerotic Cardiovascular Disease</u>					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>Diabetic mellitus; Urinary Tract Infection; Enlarged Prostate.</u>					
19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?			
22. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <u>12/17</u> 19 <u>69</u> to <u>12/20</u> 19 <u>69</u> that (I) ( <del>we</del> ) last saw the deceased alive on <u>12/20/69</u> and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) ( <del>didn't</del> ) view the body after death.					
23A. SIGNATURE <u>Walter B. Bushy</u>		23B. DATE SIGNED <u>12/20/69</u>		23C. PHYSICIAN'S NAME (Type) <u>Robert E. Taylor, M.D.</u>	
23D. ADDRESS		23E. DEGREE			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>	24B. DATE <u>12-24-69</u>	24C. NAME OF CEMETERY or CREMATORY <u>HOLY REDEEMER CEM.</u>	24D. LOCATION (City, town, or county) (State) <u>BALTO. MD.</u>		
25A. DATE REC'D BY HEALTH DEPT. <u>DEC 23 1969</u>	25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>	25C. FUNERAL DIRECTOR <u>JOHN M. WEBER</u>	ADDRESS <u>401 S. CHESTER ST.</u>		

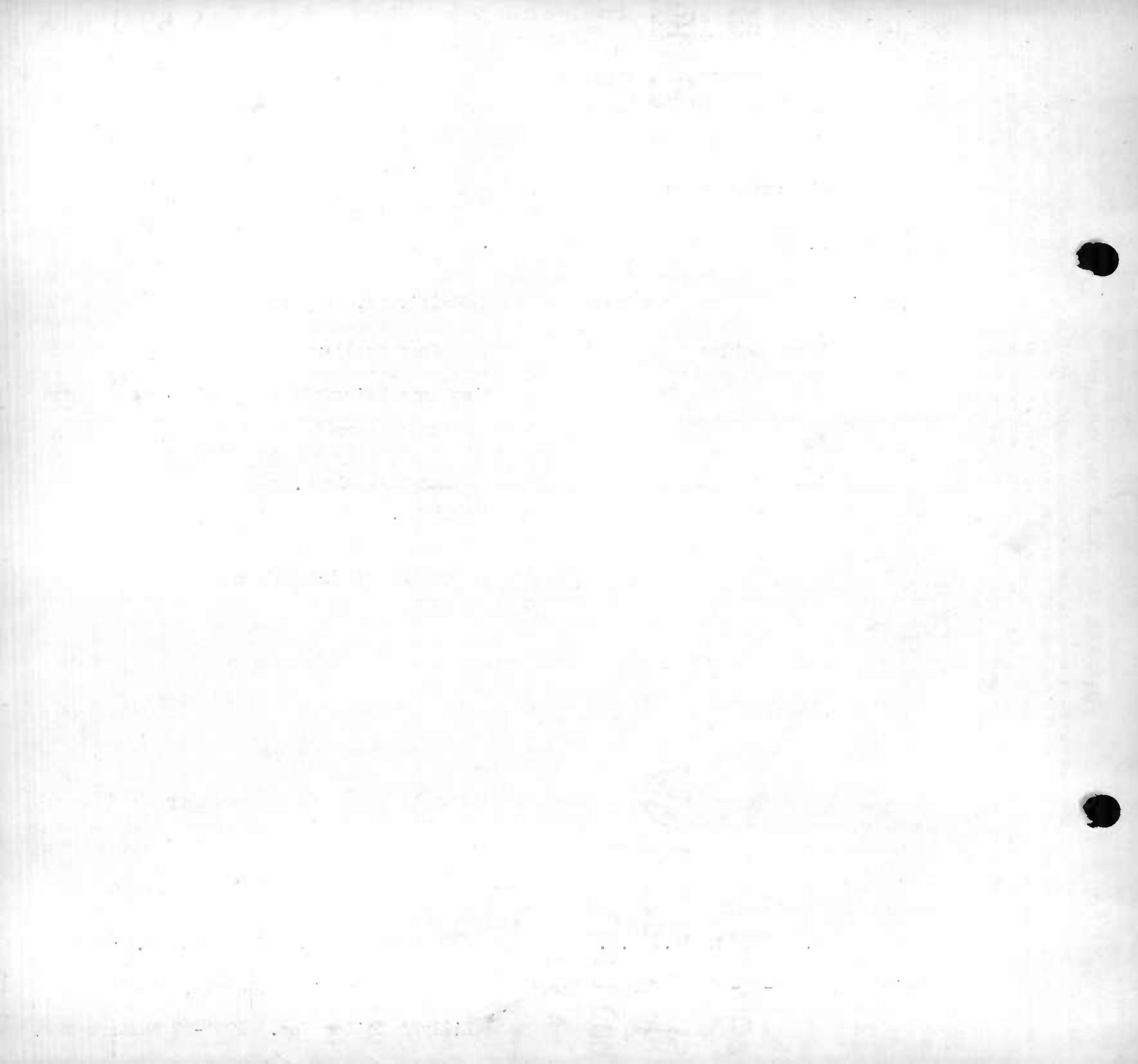


# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<div style="display: flex; justify-content: space-between;"> <span><b>R-521</b></span> <span><b>69 12647</b></span> <span>BALTIMORE CITY HEALTH DEPARTMENT</span> </div> <div style="display: flex; justify-content: space-between;"> <span><b>CERTIFICATE OF DEATH</b></span> <span>REG. NO. <b>69 12647</b></span> </div>			
BIRTH NO. <span style="float: right;">1</span> 1. NAME OF DECEASED (Type or Print) <b>KATHERINE REINSFELDER</b>		2. DATE AND HOUR OF DEATH <b>December 20, 1969</b> <span style="float: right;"><b>2:45 pm</b> M.</span>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  <div style="display: flex; justify-content: space-between;"> <span><b>00</b></span> <span><b>3327 Foster Avenue</b></span> </div>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <span style="float: right;"><b>2611</b></span> C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>3327 Foster Avenue</b>	
5. SEX <b>Female</b>	6. RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 1, 1892</b>
9. AGE (In years last birthday) <b>77</b>		If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Henry Schlee</b>		14. MOTHER'S MAIDEN NAME <b>Anna Mueller</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Miss Anna Reinsfelder</b>		ADDRESS <b>3327 Foster Avenue</b>	
18. <b>23-0-91</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  <b>CAUSE OF DEATH</b> <b>Arteriosclerotic cardiovascular disease w/fibrillation and flutter converted to normal sinus rhythm w/first degree AV block.</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Diabetes mellitus.</b> (B) DUE TO, OR AS A CONSEQUENCE OF: <b>Bladder infection</b> (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I certify that (I) <del>did not</del> attended the deceased from <b>October 24</b> 19 <b>69</b> to <b>December 20</b> 19 <b>69</b> , that (I) <del>was</del> lost saw the deceased alive on <b>December 9</b> 19 <b>69</b> and that in (my) <del>my</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>did</del> (did) <del>(did)</del> view the body after death.			
23A. SIGNATURE <b>Artemio M. Arciaga Jr.</b>		23B. DATE SIGNED <b>12/22/69</b>	
23C. PHYSICIAN'S NAME (Type) <b>ARTEMIO M. ARCIAGE, Jr., M.D.</b>		23D. ADDRESS <b>3501 Fait Avenue, Baltimore, Md. 21224</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12-24-1969</b>	
24C. NAME of CEMETERY or CREMATORY <b>Sacred Heart</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore County, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR <b>Robert E. Fisher, M.D.</b>	
25C. FUNERAL DIRECTOR <b>Lilly &amp; Zeller Inc.</b>		ADDRESS <b>1901-07 Eastern Ave.</b>	

DEC 23 1969  
VS 150-REV. 1/1/68



This certificate must be approved by the chief medical examiner on his assistant's death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

L-313

69 12648

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO.

69 12648

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

BEULAH LEDBETTER

2. DATE AND HOUR OF DEATH

12-14-69

4.45 A M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

33 THE JOHNS HOPKINS HOSPITAL

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE

B. COUNTY

MARYLAND

BALTIMORE CITY

C. CITY OR TOWN

BALTIMORE

D. INSIDE CITY LIMITS?

YES ☒NO ☐

E. STREET AND NUMBER

1607 DARLEY AVE

21218

5. SEX

FEMALE

6. RACE

NEGRO

7. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

2-5-20

9. AGE (In years  
lost birthday)

49

If Under 1 Yr.  
Months: Days: Hours: Min.If Under 24 Hrs.  
Hours: Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Domestic

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Balt. Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

James Williams

14. MOTHER'S MAIDEN NAME

Pearl Smith

15. Was Deceased Ever in U. S. Armed Forces?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Alvin Ledbetter, 1607 Darley Ave.

18. 582X1

CAUSE OF DEATH

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving  
rise to the above cause (A) stating the  
UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

Cardiac arrest

(B)

DUE TO, OR AS A CONSEQUENCE OF:

Congestive heart failure.

(C)

Chronic renal failure.

MEDICAL CERTIFICATION

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART I (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

NO

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING ☐  
OR CONTRIBUTING ☐ CAUSE OF  
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME  
OF INJURY  
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At  
Work ☐Not While  
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 19 to 19,

that (I) (we) last saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date

and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

B. Greg Brown

DEGREE

Attending  
Phys. ☐Med.  
Director ☐Staff  
Phys. ☐

23B. DATE SIGNED

23C. PHYSICIAN'S  
NAME (Type)

B. GREG BROWN

DEGREE

23D. ADDRESS

THE JOHNS HOPKINS HOSPITAL

24A. BURIAL, CREMATION,  
REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY or CREMATORY

24D. LOCATION (City, town, or county)

(State)

Burial

Dec 16/69

Mt Calvary Cem

A. A. County

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

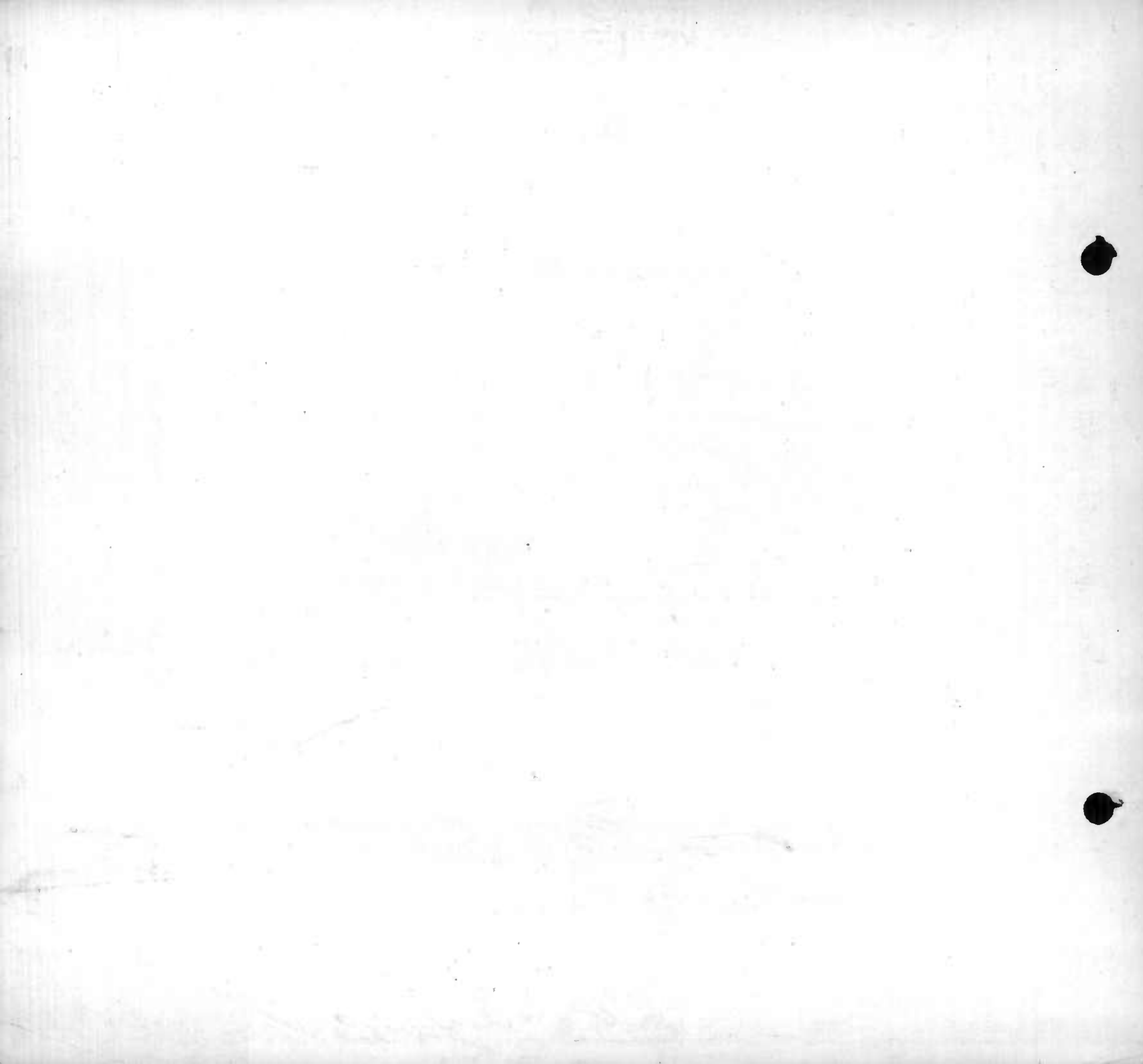
25C. FUNERAL DIRECTOR

ADDRESS

DEC 23 1969

J. E. Gibson

Milton E. Elisean 1129 N. Caroline St



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

H-100 69 12649				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 69 12649	
1. NAME OF DECEASED (Type or Print) <b>BEATRICE HUFF</b>				2. DATE AND HOUR OF DEATH <b>12/8/69 - 10:45 PM</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>604</b>			
5. SEX <b>F</b>				6. RACE <b>N</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <b>9/19/02</b>				9. AGE (In years last birthday) <b>67</b>		10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
11. BIRTHPLACE (State or foreign country) <b>Na.</b>				12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME <b>Unknown</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <b>Gloria Hall</b>	
18. <b>183.01</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>OVARIAN CARCINOMA.</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>METASTATIC DISEASE.</b>				CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>6 mos.</b>	
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION <b>2 None</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>YES.</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>12/8</b> 19 <b>69</b> to <b>12/8</b> 19 <b>69</b> , that (I) (we) last saw the deceased alive on <b>12/8</b> 19 <b>69</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>B. H. Thompson, M.D.</b>				23B. DATE SIGNED <b>12/8/69</b>		23C. PHYSICIAN'S NAME (Type) <b>BRUCE H. Thompson, M.D.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>				24B. DATE <b>Dec 12/69</b>		24C. NAME OF CEMETERY or CREMATORY <b>Baltimore Natl Cem</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 23 1969</b>				25B. NAME OF REGISTRAR <b>Robert F. Taylor, M.D.</b>		25C. FUNERAL DIRECTOR <b>Miller E. Edickson</b>	
26A. ADDRESS <b>5501 Frederick Ave</b>				26B. ADDRESS <b>1129 N. Carroll</b>			

CS 13620

Unknown  
Harris Hall

Harris Hall

Unknown



L-200

69 12650

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 69 12650

BIRTH NO.

1. NAME OF DECEASED (Type or Print) ESTELLE LEWIS		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour December 17, 1969 M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) South Baltimore General Hospital (DOA)		3. DATE PRONOUNCED DEAD Month Day Year Hour December 17, 1969 2:30 P. M.	
6. SEX Female		7. RACE Negro	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH Jan 13-24		10. AGE (in years last birthday) 45	
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY?	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machine Operator		14B. KIND OF BUSINESS OR INDUSTRY	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.	
15. FATHER'S NAME George Shunkbach		15. MOTHER'S MAIDEN NAME Henrietta	
18. INFORMANT Orbin Lewis		ADDRESS 2729 E. Biddle St	
19. 412.2 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Hypertensive and arteriosclerotic cardiovascular disease		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIB. <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME OF INJURY (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Charles S. Springate M.D. EXAMINER'S NAME (Type) Charles S. Springate, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED December 18, 1969			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE Dec 22/69	
24C. NAME of CEMETERY or CREMATORY Arbutus Mem. Park		24D. LOCATION (City, town, or county) (State) Arbutus Md.	
25A. DATE REC'D BY HEALTH DEPT. DEC 23 1969		25B. NAME OF REGISTRAR Robert L. Galt, M.D.	
25C. FUNERAL DIRECTOR Walter E. Hickman		ADDRESS 1324 N. Caroline	

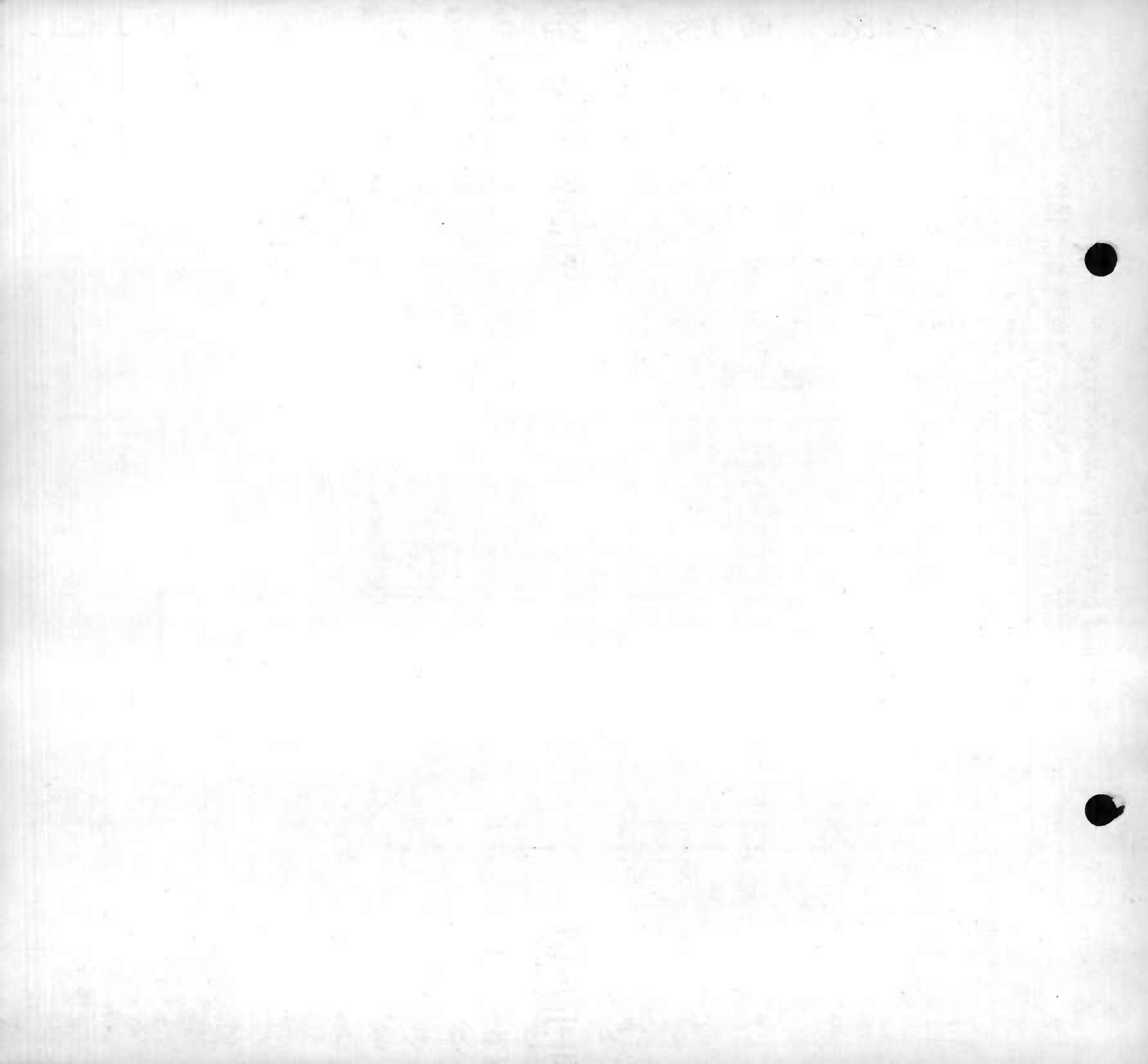
VALLEY OF THE  
RIVER OF THE  
MOUNTAINS

THE  
MOUNTAINS  
OF THE  
VALLEY

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

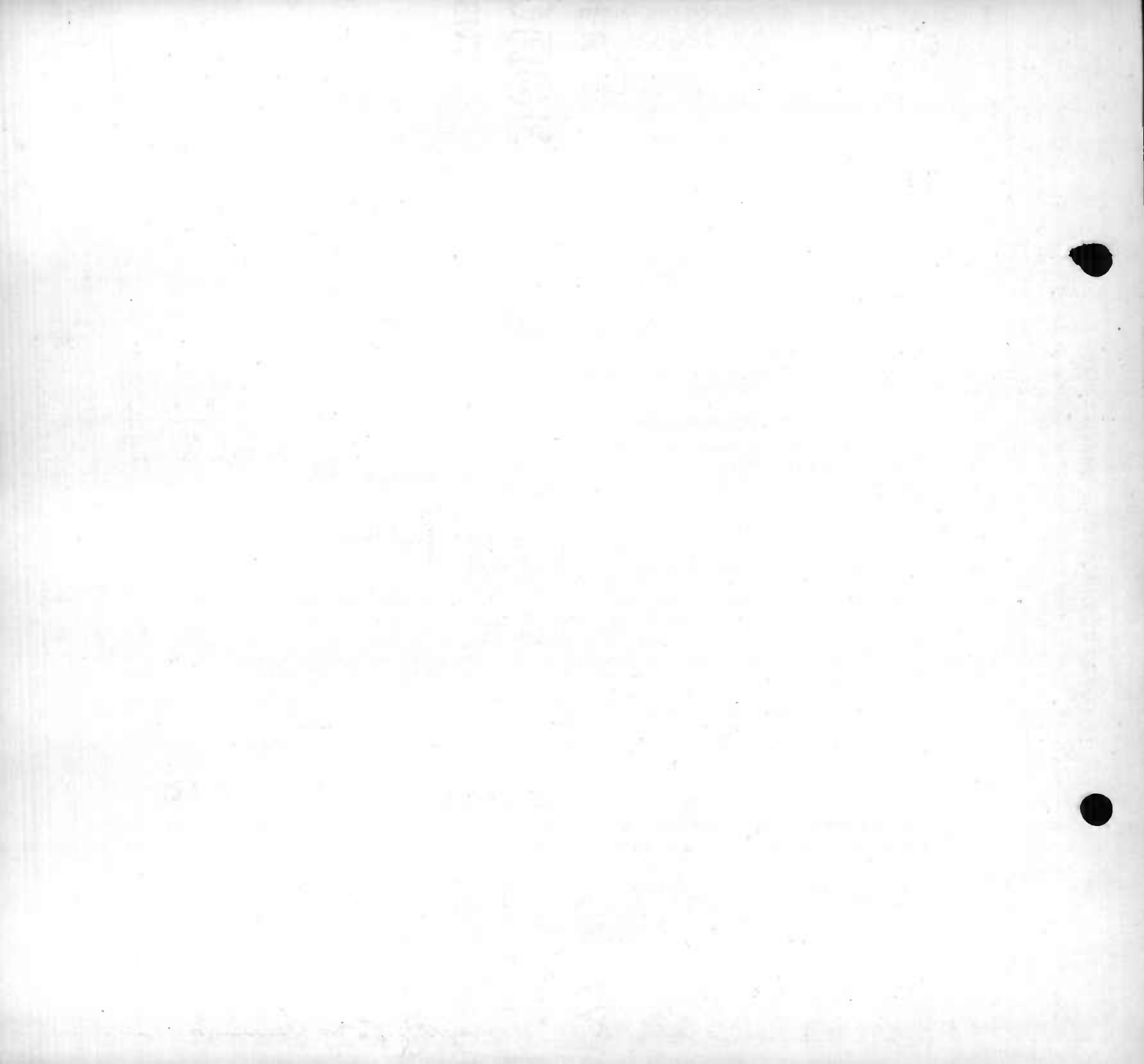
H-630		69 12651		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 69 12651	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) <i>Willard J. Howard</i>			
2. DATE AND HOUR OF DEATH <i>December 20 1969 6P.M.</i>							
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>70 Arue In The Pines Nursing Home 2525 Belvedere Ave.</i>				A. STATE <i>MD</i> B. COUNTY <i>807</i>			
C. CITY OR TOWN <i>Baltimore</i>				D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			
E. STREET AND NUMBER <i>1415 N. Bond St.</i>							
5. SEX <i>Male</i>	6. RACE <i>Colored</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Dec. 12, 1901</i>	9. AGE (In years lost birthday) <i>68</i>	10. Under 1 Yr. Months: Days: Hours: Min.	11. Under 24 Hrs. Hours: Min.	12. CITIZEN OF WHAT COUNTRY?
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired Mechanic</i>				10B. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) <i>Baltimore Md.</i>				12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME <i>Clarence J. Howard</i>				14. MOTHER'S MAIDEN NAME <i>Annie Simpson</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) <i>No</i>				16. SOCIAL SECURITY NO.			
17. INFORMANT <i>Eva Howard</i>				ADDRESS			
18. <i>188 X I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxiation, etc. It means the disease, injury or complication which caused death.)				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Carcinoma of Bladder</i> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 year</i>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>No</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>Nov 68</i> to <i>Dec. 20</i> 19 <i>69</i> , that (I) (we) last saw the deceased alive on <i>Dec 15</i> 19 <i>69</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>F.K. Adams</i>				23B. DATE SIGNED <i>Dec 23 69</i>			
23C. PHYSICIAN'S NAME (Type) <i>F.K. ADAMS</i>				23D. ADDRESS <i>12227 N. Caroline St.</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>12/24/69</i>		24C. NAME OF CEMETERY or CREMATORY <i>Mt. Auburn Cmc.</i>		24D. LOCATION (City, town, or county) (State) <i>Westport, Md.</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>DEC 23 1969</i>		25B. NAME OF REGISTRAR <i>Robert E. Fisher, M.D.</i>		25C. FUNERAL DIRECTOR <i>Bright &amp; Blum</i>		ADDRESS <i>1129 N. Caroline St.</i>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

W-452		69 12652		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 69 12652	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) <b>MAYBELLE WILLIAMS</b>			
2. DATE AND HOUR OF DEATH <b>9/12/16/69</b>				3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			
FULL NAME OF HOSPITAL OR INSTITUTION <b>33 The Johns Hopkins Hospital</b>				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>1538</b>			
C. CITY OR TOWN <b>Baltimore</b>				D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			
E. STREET AND NUMBER <b>2503 Elsinore Avenue</b>							
5. SEX <b>Female</b>		6. RACE <b>Negro</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>3/15/12</b>	
9. AGE (In years last birthday) <b>57</b>		If Under 1 Yr. Months: Days: Hours: Min.		10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>homemaker</b>		10B. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>VA.</b>				12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME <b>David Wright</b>				14. MOTHER'S MAIDEN NAME <b>Mary Little</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <b>Walter James 2/11/11 Saratoga St</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) <b>43674-2509</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b>				CAUSE OF DEATH (A) IMMEDIATE CAUSE <b>Circulatory collapse. Metabolic</b> DUE TO, OR AS A CONSEQUENCE OF: (B) <b>Renal failure</b> DUE TO, OR AS A CONSEQUENCE OF: (C) <b>EVA.</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>12 hr</b> <b>5 yr</b> <b>10 yr</b>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>Diabetes.</b>							
19A. DATE OF OPERATION <b>2/10/69</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>No</b>		20A. ANTOPSY? (Yes or No) <b>Yes</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>NO</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <b>No</b>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>2/10/69</b> 19 to <b>2/16</b> 19, that (I) (we) lost saw the deceased alive on <b>2/16/69</b> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Charles S. Angell, M.D.</b>				23B. DATE SIGNED <b>12/16/69</b>		23C. PHYSICIAN'S NAME (Type) <b>Charles S. Angell, M.D.</b>	
23D. ADDRESS <b>The Johns Hopkins Hospital</b>				23E. FUNERAL DIRECTOR <b>John E. Elshorn</b>		23F. ADDRESS <b>1129 N. Carroll St</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>Dec 20/69</b>		24C. NAME OF CEMETERY or CREMATORY <b>Mt. Auburn Cem</b>		24D. LOCATION (City, town, or county) (State) <b>Westport Md</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 23 1969</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor, M.D.</b>		25C. FUNERAL DIRECTOR <b>John E. Elshorn</b>		25D. ADDRESS <b>1129 N. Carroll St</b>	



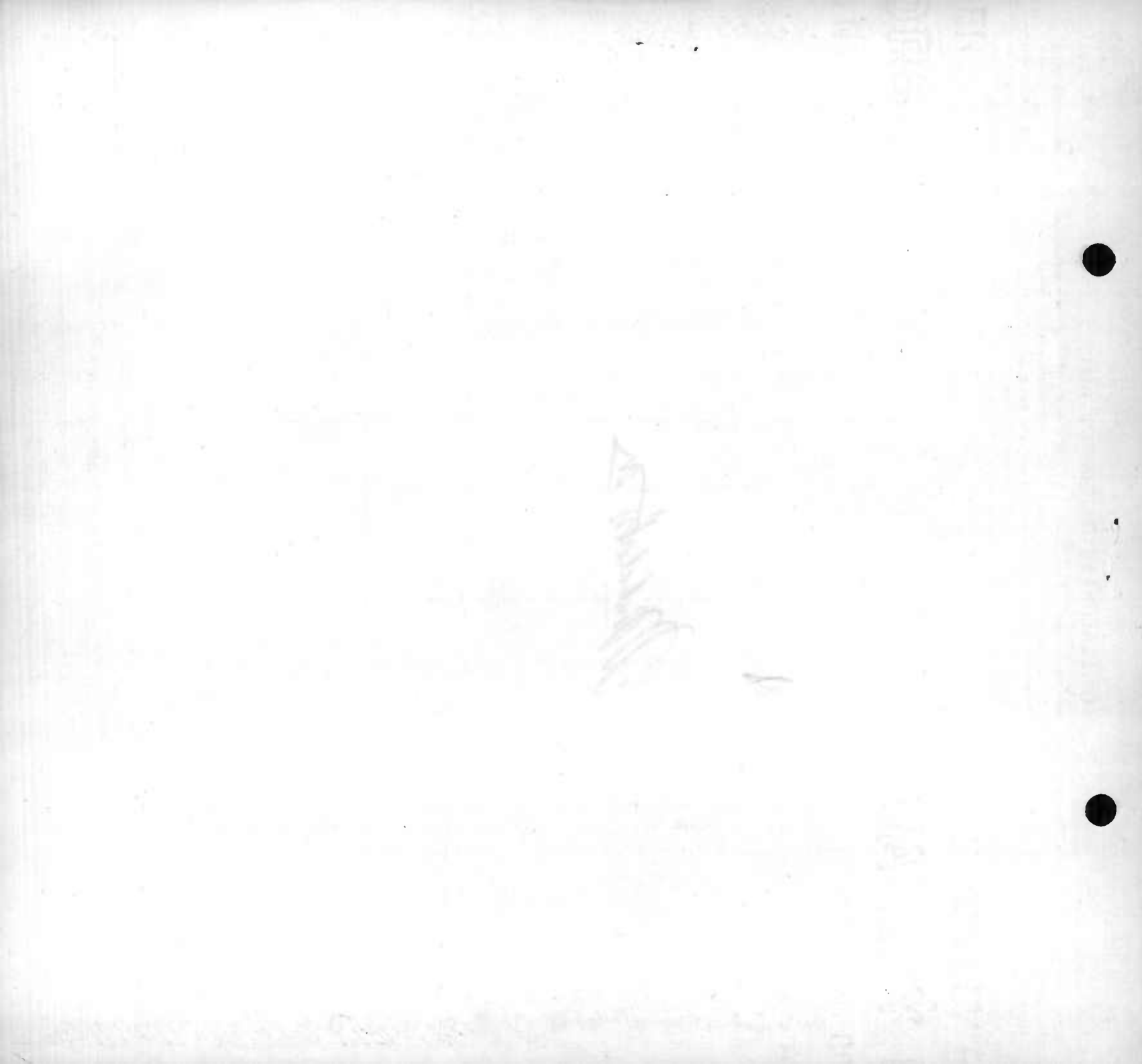


Medical Examiner Case released on Approval by Dr. Michalakus

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-400		69 12653		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 69 12653	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) RUFFIN BEAL			
2. DATE AND HOUR OF DEATH Dec. 21, 1969 11:30 P.M.				3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 33 The Johns Hopkins Hospital				4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) Maryland 808			
C. CITY OR TOWN Baltimore				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
E. STREET AND NUMBER 1052 N. Broadway							
5. SEX Male		6. RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1/16/05	
9. AGE (In years last birthday) 63		If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemp. Laborer				10B. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) No.				12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME John Beal				14. MOTHER'S MAIDEN NAME Bella Jones			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				CAUSE OF DEATH C.V.A. with Intra-ventricular hemorrhage H.A.S.C.V.D. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 hrs.			
19A. DATE OF OPERATION 0				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Dec 20 1969 to Dec 21 1969, that (I) (we) last saw the deceased alive on Dec 21 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Cesar Delgado M.D.				23B. DATE SIGNED 12/21/69		23C. PHYSICIAN'S NAME (Type) CESAR DELGADO	
23D. ADDRESS Johns Hopkins Hospital				23E. FUNERAL DIRECTOR		23F. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial				24B. DATE Dec 27/69		24C. NAME OF CEMETERY or CREMATORY Mt. Calvary Cem.	
24D. LOCATION A. A. County				24E. DATE REC'D BY HEALTH DEPT. DEC 23 1969		24F. NAME OF REGISTRAR	
24G. NAME OF REGISTRAR				24H. DATE REC'D BY HEALTH DEPT.		24I. NAME OF REGISTRAR	





J-250

69 12654

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 69 12654

BIRTH NO. 69-16938

1. NAME OF DECEASED (Type or Print) John Jackson, Jr.

2. DATE OF DEATH Known ☒ Estimated ☐ Month Day Year Hour M. 12 13 69 2:28 a.m.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 1635 Barnes St.

3. DATE PRONOUNCED DEAD Month Day Year Hour 12 13 69 2:28 a.m.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 704

6. SEX male 7. RACE colored 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES ☐ NO ☐

9. DATE OF BIRTH Sept 26 10. AGE (In years lost birthday) 3 11. BIRTHPLACE (State or foreign country) Barb. Ind. 12. CITIZEN OF WHAT COUNTRY 13. FATHER'S NAME John Jackson

14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 14B. KIND OF BUSINESS OR INDUSTRY 15. MOTHER'S MAIDEN NAME Mary Toles

16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) 17. SOCIAL SECURITY NO. 18. INFORMANT Mary Toles ADDRESS

19. #84X1 CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). (A) IMMEDIATE CAUSE (SDII) Interstitial pneumonitis DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

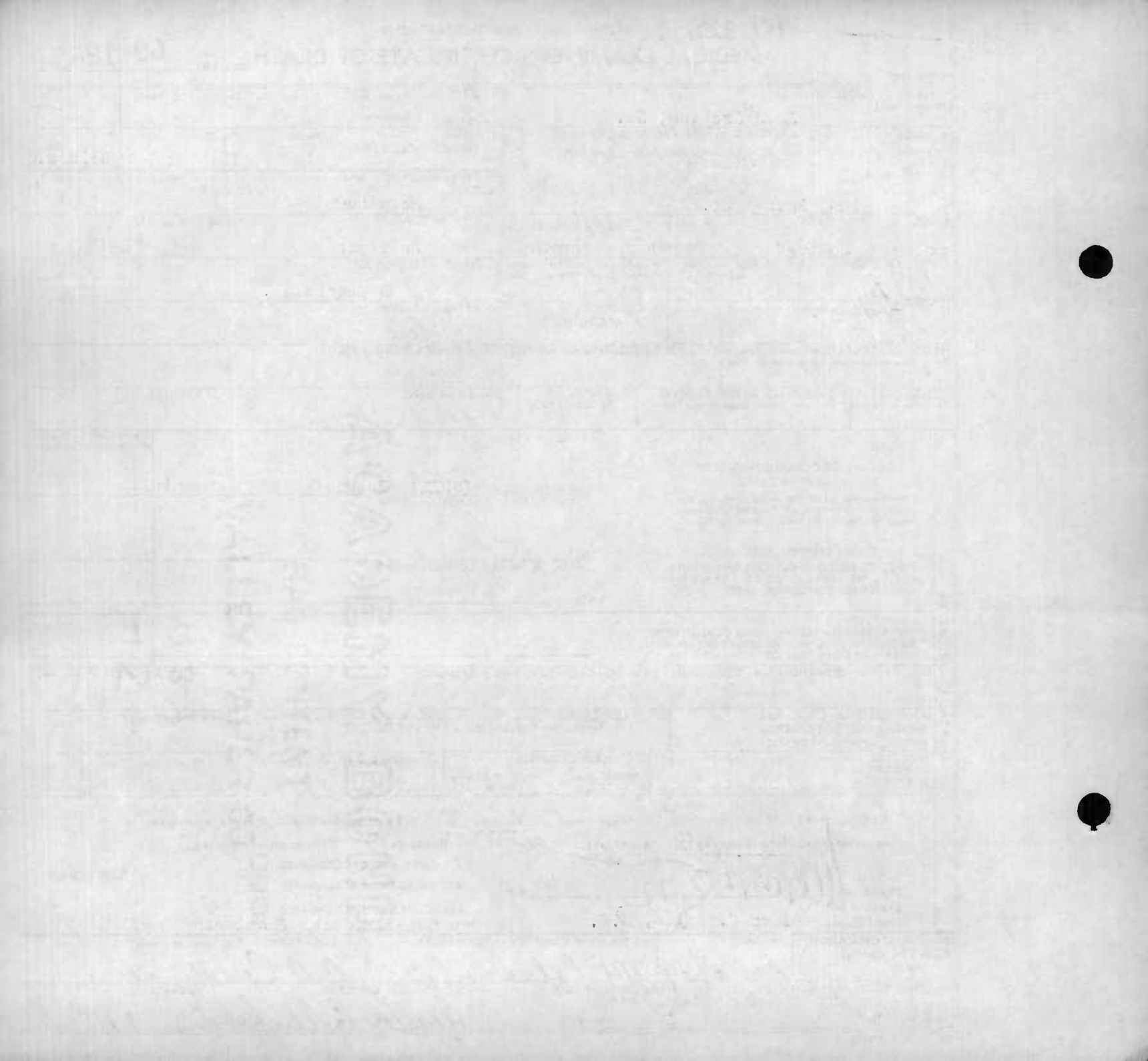
20A. DATE OF OPERATION 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED 21. AUTOPSY? (Yes or No) yes

22A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? 22D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) 22E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ 22F. HOW DID INJURY OCCUR?

23. I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ ACTUAL SIGNATURE EXAMINER'S NAME (Type) Werner U. Spitz, M.D. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ ASSOCIATE MEDICAL EXAMINER ☐ DATE SIGNED 12/13/69

24A. BURIAL CREMATION, REMOVAL (Specify) 24B. DATE 24C. NAME OF CEMETERY or CREMATORY 24D. LOCATION (City, town, or county) (State) 25A. DATE REC'D BY HEALTH DEPT. 25B. NAME OF REGISTRAR 25C. FUNERAL DIRECTOR ADDRESS

DEC 23 1969 Robert E. Barber, M.D. My Calvary Cem. A.A. County Md. M. E. Elckeson 1129 N. Carroll St.

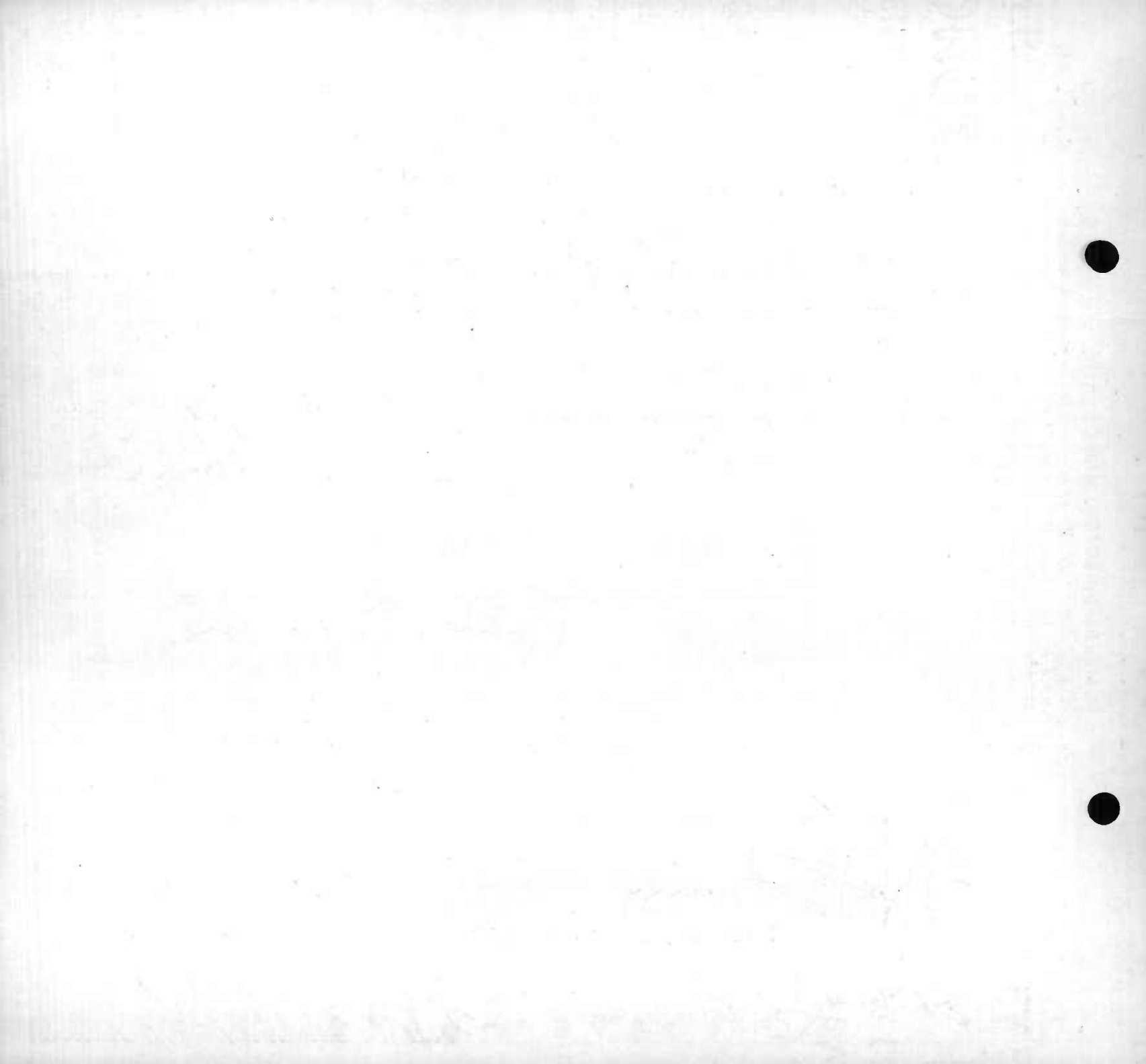


FUNERAL DIRECTOR: IMPORTANT

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King, Eula  
61 22 67

K-520		69 12655		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 69 12655	
BIRTH NO.				1			
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH		PM	
EULA KING				12-18-69		4:30	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE B. COUNTY			
33 THE JOHNS HOPKINS HOSPITAL				MARYLAND 1002			
5. SEX		6. RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH	
FEMALE		NEGRO		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5-3-22	
9. AGE (In years lost birthday)		10. A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
47		Housewife		Va			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
						Anna Singleton 2427 E. Prentiss	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES				Pulmonary Embolism Instant			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO, OR AS A CONSEQUENCE OF:			
				(C) DUE TO, OR AS A CONSEQUENCE OF:			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				Diabetes, Depression			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
2				YES		YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from 11/29/69 to 12/16/69, that (I) (we) last saw the deceased alive on 12/16/69, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
Hayden G. Braine, M.D.				12/19/69			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
				The Johns Hopkins Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		12/22/69		Mt Auburn Cem.		Westport, Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
DEC 23 1969		Robert G. [unclear]		Frederick T. Edickson		1129 N. Caroline ST	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<div style="display: flex; justify-content: space-between;"> <span>T-520</span> <span>69 12656</span> <span>BALTIMORE CITY HEALTH DEPARTMENT</span> </div> <div style="text-align: center;"> <h2 style="margin: 0;">CERTIFICATE OF DEATH</h2> </div>		REG. NO. <span style="font-size: 1.2em;">69 12656</span>	
BIRTH NO. _____ 1. NAME OF DECEASED (Type or Print) <span style="font-size: 1.1em;">Lee Thomas</span>		2. DATE AND HOUR OF DEATH <div style="display: flex; justify-content: space-between;"> <span style="font-size: 1.1em;">15 Dec 69</span> <span style="font-size: 1.1em;">5:45A M.</span> </div>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <span style="font-size: 1.5em;">33</span> Johns Hopkins Hospital		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <span style="font-size: 1.1em;">Maryland</span> B. COUNTY <span style="font-size: 1.5em;">808</span> C. CITY OR TOWN <span style="font-size: 1.1em;">Baltimore</span> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <span style="font-size: 1.1em;">1015 McDonough St</span>	
5. SEX <span style="font-size: 1.1em;">M</span>	6. RACE <span style="font-size: 1.1em;">N</span>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <span style="font-size: 1.1em;">4/17/13</span>
9. AGE (In years last birthday) <span style="font-size: 1.1em;">56</span>		If Under 1 Yr. Months: _____ Days: _____	If Under 24 Hrs. Hours: _____ Min. _____
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.1em;">Laborer</span>		10B. KIND OF BUSINESS OR INDUSTRY <span style="font-size: 1.1em;">Steelworker</span>	
11. BIRTHPLACE (State or foreign country) <span style="font-size: 1.1em;">North Carolina</span>		12. CITIZEN OF WHAT COUNTRY? <span style="font-size: 1.1em;">US</span>	
13. FATHER'S NAME <span style="font-size: 1.2em;">Calvin Thomas</span>		14. MOTHER'S MAIDEN NAME <span style="font-size: 1.2em;">Ella Walden</span>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT <span style="font-size: 1.2em;">Olki Thomas</span>
18. ADDRESS			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <span style="font-size: 1.5em;">162.1 I</span>		CAUSE OF DEATH (A) IMMEDIATE CAUSE <span style="font-size: 1.1em;">Massive Hemoptysis</span> DUE TO, OR AS A CONSEQUENCE OF: (B) <span style="font-size: 1.1em;">Bronchiogenic carcinoma</span> DUE TO, OR AS A CONSEQUENCE OF: (C) _____	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <span style="font-size: 1.1em;">3-4 minutes</span>  <span style="font-size: 1.1em;">3 mos</span>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION <span style="font-size: 1.1em;">0</span>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) <span style="font-size: 1.5em;">No</span>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <span style="font-size: 1.1em;">13 December 1969</span> to <span style="font-size: 1.1em;">15 December 69</span> 19_____, that (I) (we) last saw the deceased alive on <span style="font-size: 1.1em;">15 December 19 69</span> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <span style="font-size: 1.2em;">W. J. Rogers M.D.</span>		23B. DATE SIGNED <span style="font-size: 1.1em;">15 Dec 69</span>	
23C. PHYSICIAN'S NAME (Type) <span style="font-size: 1.1em;">W. J. Rogers MD</span>		23D. ADDRESS <span style="font-size: 1.1em;">Johns Hopkins Hospital, Baltimore, Md.</span>	
24A. BURIAL CREMATION, REMOVAL (Specify) <span style="font-size: 1.1em;">Burial</span>		24B. DATE <span style="font-size: 1.1em;">12/19/69</span>	
24C. NAME OF CEMETERY OR CREMATORY <span style="font-size: 1.1em;">Mt Auburn Cem</span>		24D. LOCATION (City, town, or county) (State) <span style="font-size: 1.1em;">Westport Md.</span>	
25A. DATE REC'D BY HEALTH DEPT. <span style="font-size: 1.2em;">DEC 23 1969</span>		25B. NAME OF REGISTRAR <span style="font-size: 1.1em;">Robert E. Faber, M.D.</span>	
25C. FUNERAL DIRECTOR <span style="font-size: 1.1em;">J. E. ...</span>		ADDRESS <span style="font-size: 1.1em;">1129 N. ...</span>	

W. J. G. W.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

J-250 69 12657		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 69 12657	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>QUEENIE V. JACKSON</b>		2. DATE AND HOUR OF DEATH <b>12/14/69 1:35 P.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>2716</b>		C. CITY OR TOWN <b>Baltimore</b>	
FULL NAME OF HOSPITAL OR INSTITUTION <b>31</b> <b>BALTIMORE CITY HOSPITALS</b> <b>4940 Eastern Avenue</b> <b>Baltimore, Maryland 21224</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		E. STREET AND NUMBER <b>2848 Oakford Avenue 21215 007</b>	
5. SEX <b>Female</b>	6. RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12-6-95</b>	9. AGE (In years last birthday) <b>74</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Wesley</b>		14. MOTHER'S MAIDEN NAME <b>Sarah</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <b>BCH-Records 4940 Eastern Avenue</b> <b>Baltimore, Maryland 21224</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>4-5-8-9 I</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>B-K AMPUTATION (2) LEG, CHOLECYSTECTOMY</b>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>RESPIRATORY ARREST</b> (B) <b>COPD, CARDIAC FAILURE, SEPSIS</b> DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION <b>12/10/69 &amp; 12/7/69</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>ISQUEMIA (2) FOOT AND CHOLECYSTITIS</b>		20A. AUTOPSY? (Yes or No) <b>Yes</b>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from <b>11/24/69</b> 19 to <b>12/14/69</b> 19 that (I) (we) last saw the deceased alive on <b>12/14/69</b> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		23A. SIGNATURE <b>Juan De Dios Lora</b>	
23B. DATE SIGNED <b>12/14/69</b>		23C. PHYSICIAN'S NAME (Type) <b>JUAN DE DIOS LORA MD</b>		23D. ADDRESS <b>BCH 4940 Eastern Avenue</b> <b>Baltimore, Maryland 21224</b>	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <b>12/18/69</b>		24C. NAME OF CEMETERY or CREMATORY <b>Mt Calvary Cem</b>	
24D. LOCATION (City, town, or county) (State) <b>A.A. County Md.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>DEC 23 1969</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor, R.D. 9 0 0 0</b>	
25C. FUNERAL DIRECTOR <b>Grady J. Elickson 11297 Carlinist</b>		25D. ADDRESS		25E. ADDRESS	





1

D-000 69 12658

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 69 12658

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Katie Day		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 33 Hopkins Hospital		3. DATE PRONOUNCED DEAD Month Day Year Hour 12 13 69 5:30 p. M.	
6. SEX female		7. RACE colored	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH Oct 1, 1929		10. AGE (In years last birthday) 40	
11. BIRTHPLACE (State or foreign country) Wake County N.C.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Nash Horton		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sales Gen. (Bureau of Census)	
15. MOTHER'S MAIDEN NAME Alberta Mitchell		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	
17. SOCIAL SECURITY NO.		18. INFORMANT Daniel Day	
19. 412.21 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Hypertensive cardiovascular disease (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		ADDRESS 1729 E. Oliver St. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) yes			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE EXAMINER'S NAME (Type) Werner U. Spitz, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> Deputy Chief Medical Examiner DATE SIGNED 12/14/69			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/18/69	
24C. NAME OF CEMETERY or CREMATORY Ball's Neck Cem.		24D. LOCATION (City, town, or county) (State) 5501 Frederick Ave	
25A. DATE REC'D BY HEALTH DEPT. DEC 23 1969		25B. NAME OF REGISTRAR Robert E. Gable	
25C. FUNERAL DIRECTOR		ADDRESS 1129 N. Carroll St	

VS 151-REV. 1/1/68

RECEIVED BY THE DEATH

10-100

ALBANY, N. Y.

ALBANY, N. Y.

ALBANY, N. Y.

**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-650		69 12659		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 69 12659	
1. NAME OF DECEASED (Type or Print) <b>HATTIE RUTH BROWN</b>				2. DATE AND HOUR OF DEATH <b>DEC. 15, 1969</b> <b>A</b> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>UNION MEMORIAL HOSPITAL</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>908</b>			
5. SEX <b>F</b>		6. RACE <b>NEGRO</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>01-04-15</b>	
9. AGE (In years last birthday) <b>54</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		11. BIRTHPLACE (State or foreign country) <b>N. CAROLINA</b>		12. CITIZEN OF WHAT COUNTRY? <b>AMERICAN</b>	
13. FATHER'S NAME <b>BEN JOHNSON</b>				14. MOTHER'S MAIDEN NAME <b>HATTIE JOHNSON</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>HOSPITAL RECORD</b>		ADDRESS <b>UMH</b>	
18. <b>133.0</b> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury at complication which caused death.) <b>Hypoglycemia</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Carcinomatosis</b> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>4-5 days</b> <b>2 years</b>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <b>Feb 68</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>CA of Cecum</b>		20A. AUTOPSY? (Yes or No) <b>NO</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <b>NO</b>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>12-09</b> 19 <b>69</b> to <b>12-15</b> 19 <b>69</b> , that (I) (we) last saw the deceased alive on <b>12-15</b> 19 <b>69</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Victorina S. Yu</b>				23B. DATE SIGNED <b>Dec. 15, 1969</b>			
23C. PHYSICIAN'S NAME (Type) <b>VICTORINA S. YU, MD.</b>				23D. ADDRESS <b>UNION MEMORIAL HOSPITAL</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>Nov 19/69</b>		24C. NAME OF CEMETERY or CREMATORY <b>Baltimore Nat. Cem.</b>		24D. LOCATION (City, town, or county) (State) <b>5501 Federal Ave.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 23 1969</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR ADDRESS <b>William E. Elickson 1129 N. Carroll St</b>			

Union Memorial Hospital

F. Neeson

Housesite

Ben Johnson

01-04-18

Mr. Carlin

Wattie Johnson

Hospital Record

12-09

12-12

12-12

12-12

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 69 12660	
BIRTH NO. 65 27553 69 12660		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) ANDREA F. ALEXANDER		2. DATE AND HOUR OF DEATH 12-18-69 5:50 PM			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 33 THE JOHNS HOPKINS HOSPITAL		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 906 C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 2866 HARFORD ROAD			
5. SEX FEMALE	6. RACE NEGRO	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-6-65	9. AGE (In years last birthday) 4	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore	
12. CITIZEN OF WHAT COUNTRY		13. FATHER'S NAME CHARLES L. ALEXANDER		14. MOTHER'S MAIDEN NAME MATILDA J. GROOM	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Hospital Record	
18. 746.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) slowing the UNDERLYING CONDITION lost. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		CAUSE OF DEATH (A) IMMEDIATE CAUSE CARDIAC ARREST DUE TO, OR AS A CONSEQUENCE OF: (B) POST OPERATIVE REPAIR OF DUE TO, OR AS A CONSEQUENCE OF: (C) TRANSPOSITION OF GREAT VESSELS		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION 3-12-17-69		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED TRANSPOSITION OF GREAT VESSELS		20A. AUTOPSY? (Yes or No) YES	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examined)			
21B. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED White At <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 12-15 19 69 to 12-18 1969 that (I) (we) last saw the deceased alive on 12-18-69 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE J. Reynolds M.D.		23B. DATE SIGNED 12-18-69		23C. PHYSICIAN'S NAME (Type) J. REYNOLDS M.D.	
23D. ADDRESS THE JOHNS HOPKINS HOSPITAL		24A. BURIAL CREMATION, REMOVAL (Specify) Burial			
24B. DATE 12-23-69		24C. NAME OF CEMETERY OR CREMATORY Balb National Em Balto		24D. LOCATION (City, town, or county) (State) Md	
25A. DATE REC'D BY HEALTH DEPT DEC 23 1969		25B. NAME OF REGISTRAR Robert E. Gable		25C. FUNERAL DIRECTOR Kayner Sanders	
25D. ADDRESS 217 E. Preston St					

Butter

Wagtail

Beaver 12-22-23

Wagtail 12-22-23

P-653

## BALTIMORE CITY HEALTH DEPARTMENT

69 12661

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

69 12661

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Evelyn Pernot

2. DATE  
OF  
DEATHKnown ☐ Estimated ☐

Month

Day

Year

Hour

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL  
OR INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

3. DATE

Month

Day

Year

Hour

M.

5. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)

A. STATE

B. COUNTY

Md.

301

6. SEX

Female

7. RACE

Negro

8. MARRIED ☐NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

C. CITY OR TOWN

Balto.

D. INSIDE CITY LIMITS?

YES ☒NO ☐

9. DATE OF BIRTH

7-26-1928

10. AGE (In years  
last birthday)

60

If Under 1 Yr. If Under 24 Hrs.

Months Days Hours Min.

E. STREET AND NUMBER

1527 E. Fayette St.

11. BIRTHPLACE (State or foreign country)

Baltimore

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Adolph Burton

14A. USUAL OCCUPATION (Give kind of work  
done during normal working life, even if retired)

Domestic

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Clara Jackson

16. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)17. SOCIAL  
SECURITY NO.

18. INFORMANT

ADDRESS

Ellis Burton 1512 Wolfe St

19. 412.4

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, ashenia, etc. It means the disease,  
injury or complication which caused death.)

Arteriosclerotic cardiovascular disease

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

MEDICAL CERTIFICATION

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART I (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

no

22A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY  
(APPROX.)

22E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL

SIGNATURE

EXAMINER'S

NAME (Type)

Russell S. Fisher, M.D.

CHIEF MEDICAL EXAMINER ☒ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

12-15-69

24A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

12-18-69

24C. NAME of CEMETERY or CREMATORY

Mt Calvary Cem

24D. LOCATION (City, town, or county)

A. A. Co

(State)

Md

25A. DATE REC'D BY HEALTH DEPT.

DEC 23 1969

25B. NAME OF REGISTRAR

R. E. Fisher, M.D.

25C. FUNERAL DIRECTOR

Rayner Sanders

ADDRESS

217 E. Preston St



Elm Street 1521-1525  
Clear Jackson  
Robert Hunter

1-26-18  
Baltimore  
Attorneys

Received 12-18-18 The Secretary of R.R. Co.  
Payable to order of R.R. Co.



W-42569 12662

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 69 12662

BIRTH NO.

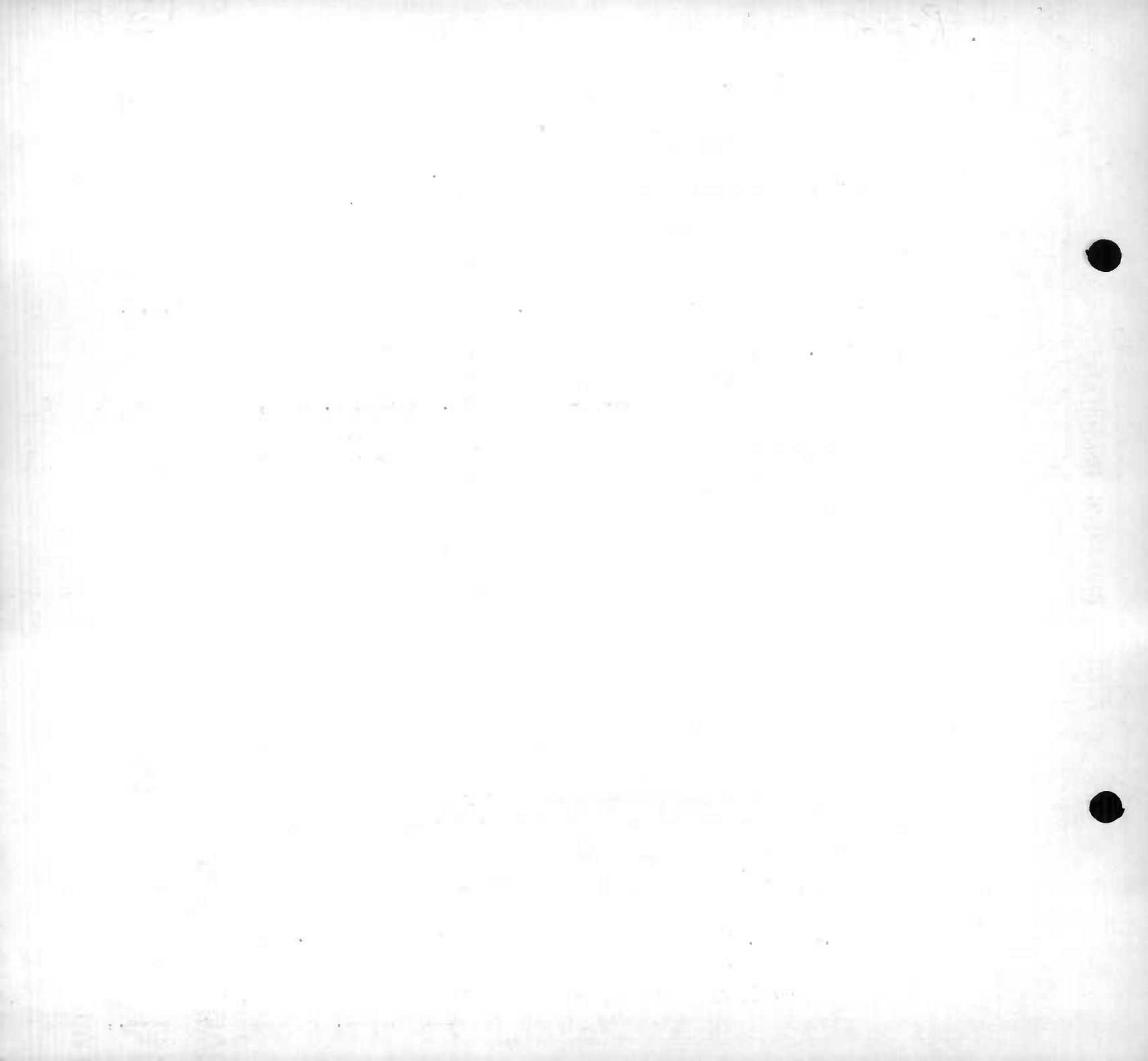
1. NAME OF DECEASED (Type or Print) <b>DAISY WILSON</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> <b>December 19, 1969</b> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>00 827 W. Baltimore Street</b>		3. DATE PRONOUNCED DEAD Month Day Year <b>December 20, 1969</b> 5:30 A. M.	
5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>1803</b>			
6. SEX <b>Female</b>	7. RACE <b>White</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	C. CITY OR TOWN <b>Baltimore</b>
9. DATE OF BIRTH <b>8/25/11</b>		10. AGE (In years last birthday) <b>58</b>	D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
11. BIRTHPLACE (State or foreign country) <b>Cumberland, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	E. STREET AND NUMBER <b>827 W. Baltimore Street, Balto., Md. 21201</b>
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY <b>Capitol Cake Co.</b>	15. MOTHER'S MAIDEN NAME
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>		17. SOCIAL SECURITY NO. <b>213-24-6463</b>	18. INFORMANT <b>Randall Wilson - 828 W. Baltimore St., Md.</b>
19. <b>174X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Metastatic Carcinoma of the breast</b> CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____ II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION <b>2</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> (Partial) Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <b>Isidore Mihalakis, M.D.</b> CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) <b>Isidore Mihalakis, M.D.</b> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <b>12/20/69</b> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12/23/69</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Hillcrest Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Cumberland, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 23 1969</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor, M.D.</b>	
25C. FUNERAL DIRECTOR <b>Witzke, 4101 Edmondson Av., Balto., Md. 21229</b>		25D. ADDRESS	

ACADEMY BOOK

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

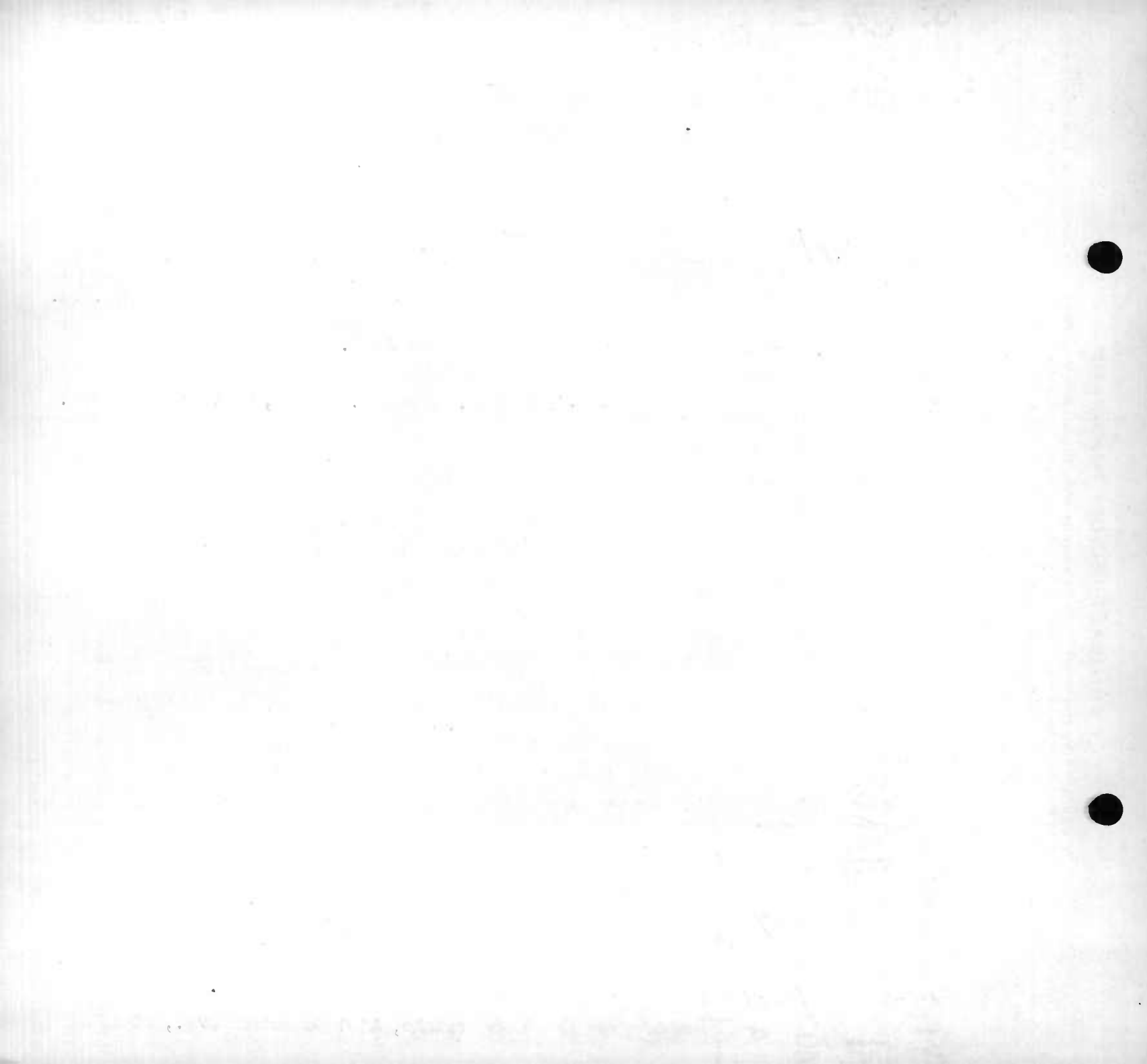
<div style="display: flex; justify-content: space-between;"> <span>R-500</span> <span>69 12663</span> <span>BALTIMORE CITY HEALTH DEPARTMENT</span> </div> <h2 style="text-align: center;">CERTIFICATE OF DEATH</h2>		REG. NO. <span style="font-size: 1.5em;">69 12663</span>	
1. NAME OF DECEASED (Type or Print) <span style="font-size: 1.2em;">William H. Ryan</span>		2. DATE AND HOUR OF DEATH <span style="font-size: 1.2em;">12/20/69</span>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <span style="font-size: 1.5em;">00</span> <span style="font-size: 1.2em;">4514 Old Frederick Road</span>		4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <span style="font-size: 1.2em;">Md</span> B. COUNTY <span style="font-size: 1.2em;">Balto</span> C. CITY OR TOWN <span style="font-size: 1.2em;">Balto.</span> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <span style="font-size: 1.2em;">4514 Old Frederick Road</span>	
5. SEX <span style="font-size: 1.2em;">Male</span>	6. RACE <span style="font-size: 1.2em;">White</span>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <span style="font-size: 1.2em;">8/19/1894</span>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">Salesman</span>		10B. KIND OF BUSINESS OR INDUSTRY <span style="font-size: 1.2em;">United Sanitary Co.</span>	9. AGE (In years last birthday) <span style="font-size: 1.2em;">75</span>
11. BIRTHPLACE (State or foreign country) <span style="font-size: 1.2em;">Maryland</span>		12. CITIZEN OF WHAT COUNTRY? <span style="font-size: 1.2em;">U.S.A.</span>	
13. FATHER'S NAME <span style="font-size: 1.2em;">William H. Ryan</span>		14. MOTHER'S MAIDEN NAME <span style="font-size: 1.2em;">Mary Gosnell</span>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <span style="font-size: 1.2em;">no</span>		16. SOCIAL SECURITY NO. <span style="font-size: 1.2em;">212-28-6609</span>	17. INFORMANT ADDRESS <span style="font-size: 1.2em;">Mrs. William H. Ryan, 4514 Frederick Road</span>
18. <span style="font-size: 1.5em;">410.91</span> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <span style="font-size: 1.5em;">Coronary Thrombosis</span> (B) <span style="font-size: 1.5em;">A.S.C.V.D.</span> DUE TO, OR AS A CONSEQUENCE OF: (C) _____	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <span style="font-size: 1.5em;">instant</span>	
19A. DATE OF OPERATION <span style="font-size: 1.5em;">0</span>	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CLINICAL CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <span style="font-size: 1.5em;">Jan</span> 19 <span style="font-size: 1.5em;">54</span> to <span style="font-size: 1.5em;">12/20</span> 19 <span style="font-size: 1.5em;">69</span> , that (I) (we) last saw the deceased alive on <span style="font-size: 1.5em;">12/19</span> 19 <span style="font-size: 1.5em;">69</span> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <span style="font-size: 1.5em;">John C. Pound M.D.</span>		Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>	23B. DATE SIGNED <span style="font-size: 1.5em;">12/22/69</span>
23C. PHYSICIAN'S NAME (Type) <span style="font-size: 1.2em;">DR. John C. Pound</span>		23D. ADDRESS <span style="font-size: 1.2em;">3325 Frederick Avenue</span>	
24A. BURIAL CREMATION, REMOVAL (Specify) <span style="font-size: 1.2em;">Burial</span>	24B. DATE <span style="font-size: 1.2em;">12/23/69</span>	24C. NAME OF CEMETERY or CREMATORY <span style="font-size: 1.2em;">Mount Olivet Cemetery</span>	24D. LOCATION (City, town, or county) (State) <span style="font-size: 1.2em;">Baltimore, Maryland</span>
25A. DATE REC'D BY HEALTH DEPT. <span style="font-size: 1.5em;">DEC 23 1969</span>	25B. NAME OF REGISTRAR <span style="font-size: 1.5em;">Robert E. Nader</span>	25C. FUNERAL DIRECTOR <span style="font-size: 1.5em;">Gitzke, Inc.</span> ADDRESS <span style="font-size: 1.2em;">1630 Edmondson Ave., 21228</span>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

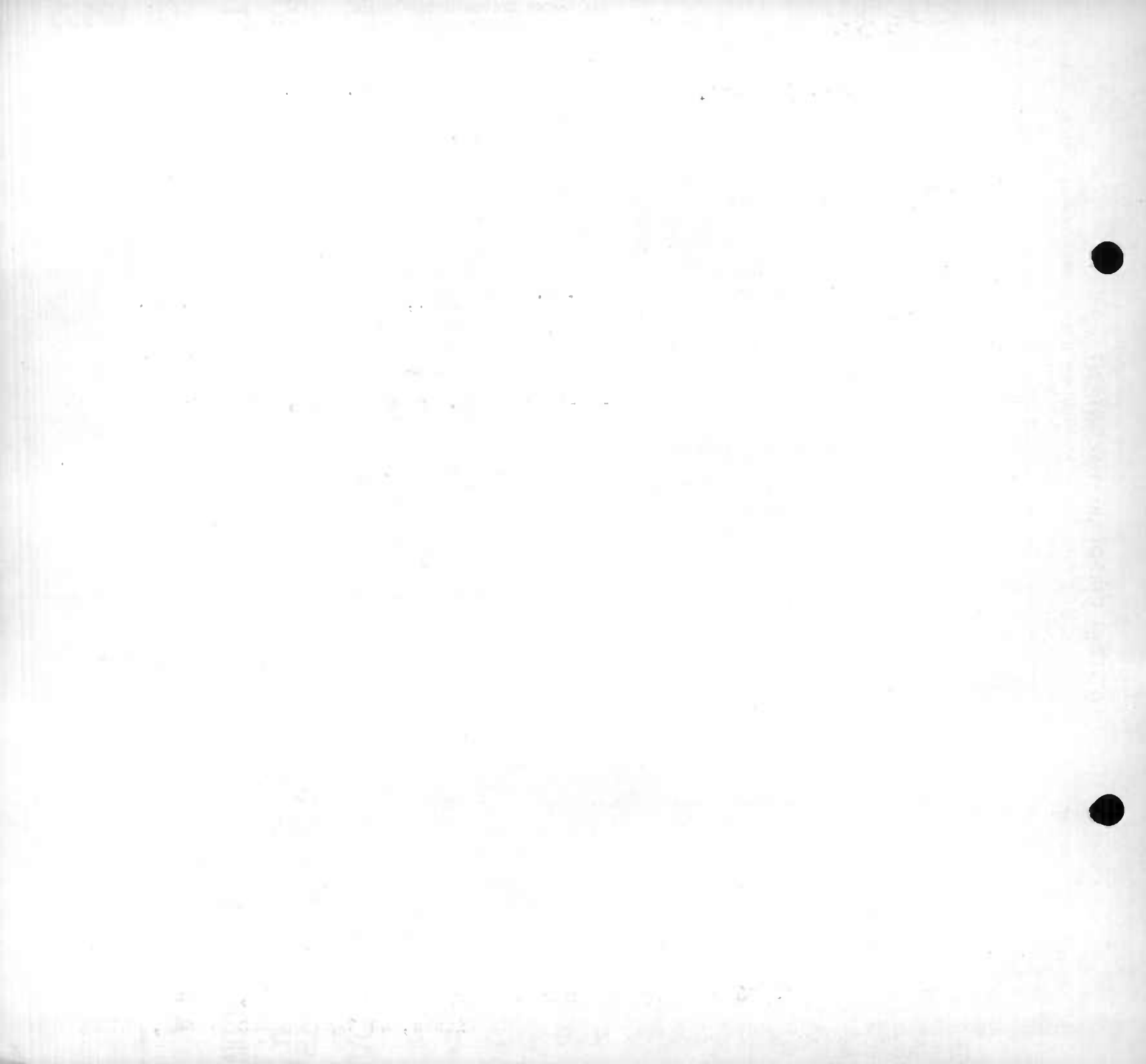
BALTIMORE CITY HEALTH DEPARTMENT		69 12664	
REG. NO. 69 12664		69 12664	
BIRTH NO. <b>R-240</b>		<b>69 12664</b> <b>CERTIFICATE OF DEATH</b>	
1. NAME OF DECEASED (Type or Print) <b>RUCKLE, RAYMOND AVE</b>		2. DATE AND HOUR OF DEATH <b>12-22-69 12 P.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE <b>MD</b> B. COUNTY <b>BAITO</b>	
FULL NAME OF HOSPITAL OR INSTITUTION <b>LUTHERAN</b>		C. CITY OR TOWN <b>BAITO</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		E. STREET AND NUMBER <b>2007 LAURETTA AVE</b>	
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4/25/94</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <b>75</b>
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Walter L. Ruckle</b>		14. MOTHER'S MAIDEN NAME <b>Minnie M. Poezolt</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>WWI</b>		16. SOCIAL SECURITY NO. <b>212-05-4288A</b>	
17. INFORMANT <b>Mr. Albert H. Ruckle, 2307 Lauretta Ave.</b>		ADDRESS	
18. <b>486X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Renal failure.</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>20th Dec. 69</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>marked dehydration</b>		(B) DUE TO, OR AS A CONSEQUENCE OF: <b>22nd Dec. 69</b>	
(C) <b>Pneumonia /x</b>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>Severe Anemia.</b>			
19A. DATE OF OPERATION <b>0</b>	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) <input checked="" type="checkbox"/>	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>20 Dec 1969</b> to <b>22 Dec 1969</b> , that (i) (we) last saw the deceased alive on <b>22 Dec 1969</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <b>P. G. N. ANESWARAN M.D.</b>		23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) <b>P. G. N. ANESWARAN</b>		23D. ADDRESS <b>Lutheran Hosp Ashburton St. Balto</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>12/24/69</b>	24C. NAME OF CEMETERY OR CREMATORY <b>Baltimore National Cemetery</b>	24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 23 1969</b>	25B. NAME OF REGISTRAR <b>Robert E. Neuberger</b>	25C. FUNERAL DIRECTOR <b>Hitzke, 4107 Edmondson Ave., 21229</b>	ADDRESS



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

G-635		69 12665		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO.		69 12665	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>Eleanor B. Gardiner</b>				2. DATE AND HOUR OF DEATH <b>Dec. 22, 1969</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>2834</b>				M.			
FULL NAME OF HOSPITAL OR INSTITUTION <b>00</b> <b>4814 Coleherne Road</b>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
5. SEX <b>Female</b>		6. RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>12/6/96</b>		9. AGE (In years last birthday) <b>73</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Librarian</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Librarian</b>		11. BIRTHPLACE (State or foreign country) <b>Phila., Pa</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Brinkman</b>		14. MOTHER'S MAIDEN NAME							
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>unknown</b>		16. SOCIAL SECURITY NO. <b>578-48-5888</b>		17. INFORMANT <b>Mrs. Francis Walsh, 4814 Coleherne Road</b>		ADDRESS			
18. <b>1978 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b>		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Dehydration + Malnutrition</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <b>Carcinoma of liver - metastases</b> DUE TO, OR AS A CONSEQUENCE OF:							
(C) _____									
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).									
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <b>November 19 69</b> to <b>22 Dec 19 69</b> , that (I) (we) last saw the deceased alive on <b>22 Dec 19 69</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <b>William J. Bryson</b>		DEGREE <b>Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/></b>		23B. DATE SIGNED <b>22 Dec 69</b>					
23C. PHYSICIAN'S NAME (Type) <b>William J. Bryson M.D.</b>		23D. ADDRESS <b>4605 Edmondson Ave Balto. Md</b>							
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12/26/69</b>		24C. NAME of CEMETERY or CREMATORY <b>Holy Redeemer Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Philadelphia, Penna</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 23 1969</b>		25B. NAME OF REGISTRAR <b>Robert E. Fisher</b>		25C. FUNERAL DIRECTOR <b>Witzke, 4101 Edmondson Avenue, 21229</b>		ADDRESS			





C-652 69 12666 BALTIMORE CITY HEALTH DEPARTMENT  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH REG. NO. 69 12666

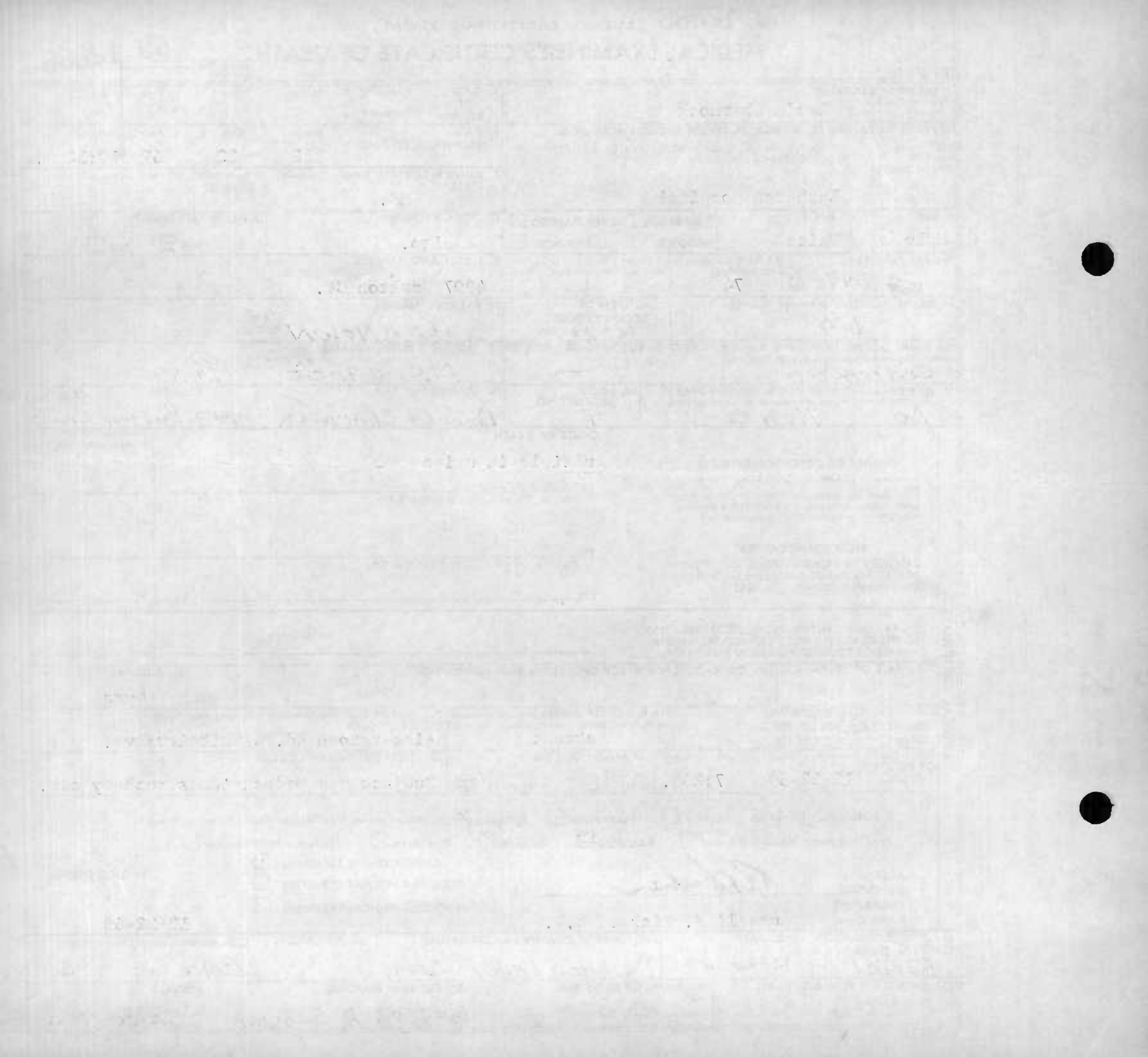
# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

69 12666

BIRTH NC.

1. NAME OF DECEASED (Type or Print) <b>Lacie Charnock</b>		2. DATE OF DEATH Known <input type="checkbox"/> Estimated <input type="checkbox"/>		Month	Day	Year	Hour
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>46 Lutheran Hospital</b>		3. DATE PRONOUNCED DEAD Month <b>12</b> Day <b>22</b> Year <b>69</b>		Hour <b>10:32 A.M.</b>			
5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>2541</b>		C. CITY OR TOWN <b>Balto.</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
6. SEX <b>Male</b>	7. RACE <b>White</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	E. STREET AND NUMBER <b>4907 Parkton Ct.</b>				
9. DATE OF BIRTH <b>12-17-95</b>	10. AGE (In years lost birthday) <b>74</b>	11. BIRTHPLACE (State or foreign country) <b>VA.</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA.</b>		13. FATHER'S NAME <b>UNKNOWN</b>		
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Contractor</b>		14B. KIND OF BUSINESS OR INDUSTRY		15. MOTHER'S MAIDEN NAME <b>MARGARET PARKS.</b>			
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		17. SOCIAL SECURITY NO. <b>None</b>		18. INFORMANT <b>Delores CHARNOCK</b>		ADDRESS <b>4907 Parkton Court BALTO, MD</b>	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>E81471</b>		CAUSE OF DEATH <b>Multiple injuries</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:					
		(B) DUE TO, OR AS A CONSEQUENCE OF:					
		(C)					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
20A. DATE OF OPERATION <b>2</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) <b>yes</b>			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>street</b>		22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>Reisterstown Rd. &amp; Whittier Ave. 1304</b>			
22D. TIME OF INJURY (APPROX.) <b>12-22-69 7:20A.M.</b>		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? <b>Subject was pedestrian struck by car.</b>			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>R. S. Fisher</b>		EXAMINER'S NAME (Type) <b>Russell S. Fisher, M.D.</b>		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <b>12-22-69</b>	
24A. BURIAL OR CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>12-26-69</b>		24C. NAME OF CEMETERY or CREMATORY <b>Dulaney Valley Cem.</b>		24D. LOCATION (City, town, or county) (State) <b>BALTO. CO. MD.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 23 1969</b>		25B. NAME OF REGISTRAR <b>Robert E. Fisher, M.D.</b>		25C. FUNERAL DIRECTOR <b>George H. Schwab</b>		ADDRESS <b>BALTO, MD.</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

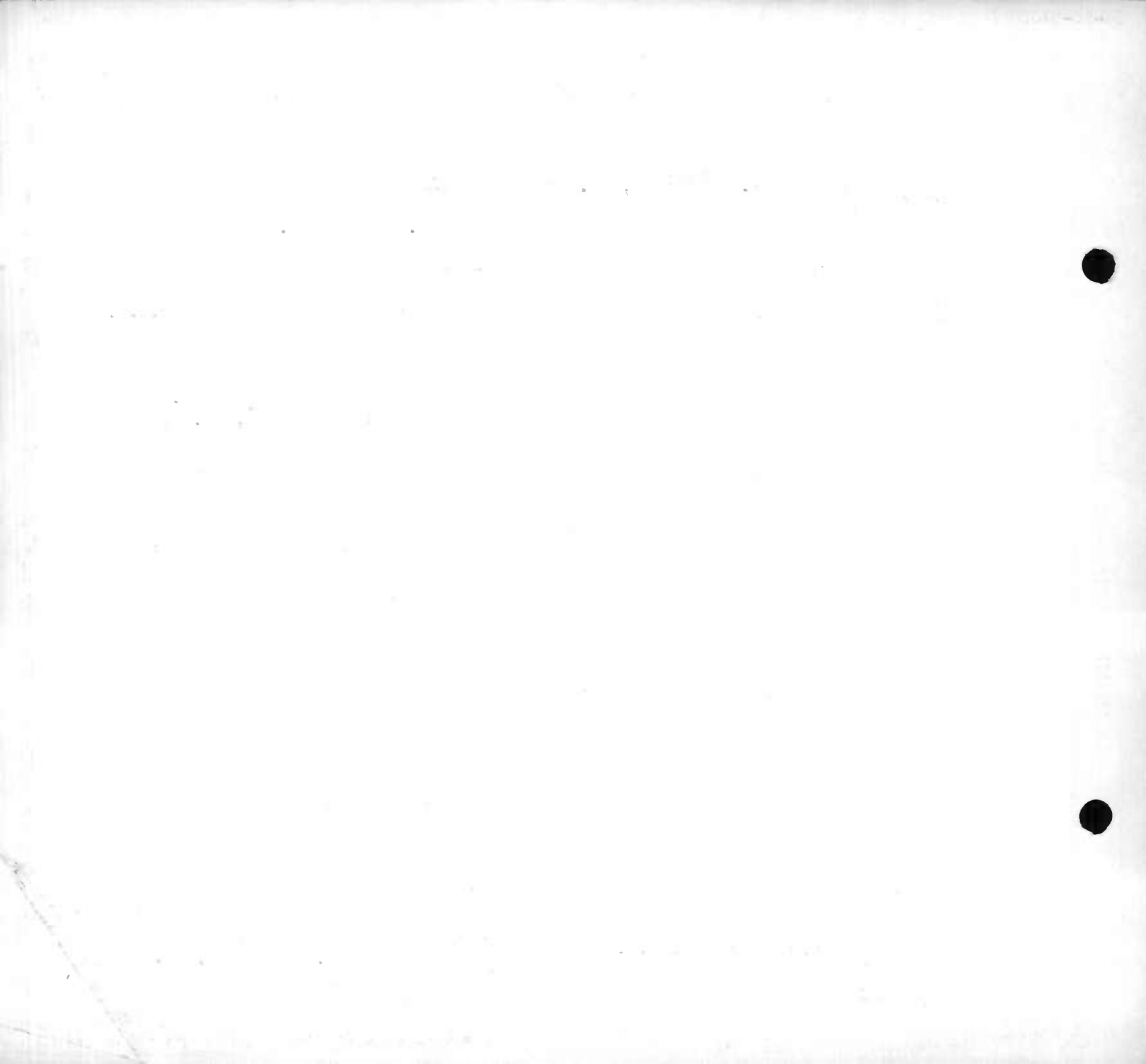
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>69 12667</u>
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH		
CLARENCE PHILLIPS		12-21-69 7:15 A.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institutions residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION 37 MERCY HOSPITAL		A. STATE MARYLAND		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
		E. STREET AND NUMBER 327 S. SMALLWOOD ST. #21223		
5. SEX MALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-9-07	9. AGE (In years last birthday) 62
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SECURITY GUARD		10B. KIND OF BUSINESS OR INDUSTRY HOSPITAL		11. BIRTHPLACE (State or foreign country) MARYLAND
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME WALTER PHILLIPS		
14. MOTHER'S MAIDEN NAME MINNIE M. FOSTER		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No None		
16. SOCIAL SECURITY NO. 220-01-4390		17. INFORMANT GLADYS PHILLIPS 327 S. SMALLWOOD ST.		
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 1/2 hrs before death		
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (1) (this hospital) attended the deceased from 11-27-1969 to 12-21-1969 that (1) (we) last saw the deceased alive on 12-21-1969 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE [Signature]		23B. DATE SIGNED 12-24-69		23C. PHYSICIAN'S NAME (Type) L. MANALO, M.D.
23D. ADDRESS To Mercy Hospital of BALTIMORE		24A. BURIAL CREMATION, REMOVAL (Specify) Burial		
24B. DATE 12-24-69		24C. NAME OF CEMETERY or CREMATORY Linden Park		24D. LOCATION (City, town, or county) (State) BALTO. Md
25A. DATE REC'D BY HEALTH DEPT. DEC 23 1969		25B. NAME OF REGISTRAR George L. Schwab		25C. FUNERAL DIRECTOR ADDRESS BALTO. Md.



## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		69 12668		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 69 12668	
1. NAME OF DECEASED (Type or Print) <b>JOSEPH A. HLAEKA</b>				2. DATE AND HOUR OF DEATH <b>12/19/69 11:00 A.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <b>BALTIMORE CITY HOSPITALS</b>				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>1803</b>			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>Baltimore City Hospitals 4940 Eastern Ave. Baltimore, Md. 21224</b>				C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <b>Male</b>				6. RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>DRUG CLERK</b>				10B. KIND OF BUSINESS OR INDUSTRY		9. AGE (in years last birthday) <b>55</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Ignatius</b>				14. MOTHER'S MAIDEN NAME <b>Sophie</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <b>4940 Eastern Ave. BCH Records: Baltimore, Md. 21224</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>RESPIRATORY ARREST</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>7 months</b>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>1° in Tongue</b>							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION <b>6/13/69 &amp; 8/20/69</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Cancer of tongue</b>		20A. AUTOPSY? (Yes or No) <b>No</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>May 22, 1969</b> to <b>12/19, 1969</b> that (I) (we) last saw the deceased alive on <b>12/19, 1969</b> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Ivens Le Flore, M.D.</b>				23B. DATE SIGNED <b>12/19/69</b>		23C. PHYSICIAN'S NAME (Type) <b>Ivens Le Flore, M.D.</b>	
24A. BURIAL OR CREMATION REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>12-23-69</b>		24C. NAME OF CEMETERY <b>NEW CATHEDRAL</b>		24D. LOCATION (City, town, or county) (State) <b>BALTO. MD.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 23 1969</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor, M.D.</b>		25C. FUNERAL DIRECTOR <b>GEORGE SCHWAB</b>		ADDRESS <b>2101 FREDERICK AVE.</b>	



BALTIMORE CITY HEALTH DEPARTMENT  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

69 12669

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

CHARLES CARR

2. DATE  
OF  
DEATHKnown ☐  
Estimated ☐

Month

Day

Year

Hour

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL  
OR INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

Sinai Hospital D.O.A.

3. DATE

PRONOUNCED DEAD

Month

Day

Year

Hour

December 18, 1969 10:14 PM

5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE

B. COUNTY

Maryland

1538

6. SEX

Male

7. RACE

Negro

8. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

C. CITY OR TOWN

Balto.

D. INSIDE CITY LIMITS?

YES ☒NO ☐

9. DATE OF BIRTH

11-26-1929

10. AGE (In years  
last birthday)

40

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.

E. STREET AND NUMBER

3721 Liberty Hgts. Ave.

11. BIRTHPLACE (State or foreign country)

Rose Hill, N. Carolina

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Charles Carr

14A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

14B. KIND OF BUSINESS OR INDUSTRY

Hudson Supply Co.

15. MOTHER'S MAIDEN NAME

Katie Carr

16. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No.

17. SOCIAL  
SECURITY NO.

18. INFORMANT

Mrs. Ora Lee Carr

ADDRESS

1527 Gorsuch Avenue

19.

CAUSE OF DEATH

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) IMMEDIATE CAUSE Epilepsy  
DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART I (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

YES

22A. EXTERNAL CAUSE WAS  
UNDERLYING ☐ OR CONTRIB-  
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (if in Baltimore City, give exact location)  
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY (APPROX.)

22E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Isidore Malakis, M.D.

CHIEF MEDICAL EXAMINER ☐  
ASSISTANT MEDICAL EXAMINER ☒  
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

24A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

12-23-69

24C. NAME OF CEMETERY or CREMATORY

New Christian Ch. Cem.

24D. LOCATION (City, town, or county) (State)

Rosehill, North Carolina

25A. DATE REC'D BY HEALTH DEPT.

DEC 23 1969

25B. NAME OF REGISTRAR

Robert E. Taylor, Jr.

25C. FUNERAL DIRECTOR

MORTON &amp; DYETT F.H. 1701 Laurens Street

ADDRESS







1

69 12670 BALTIMORE CITY HEALTH DEPARTMENT

11-245

**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

BIRTH NO. \_\_\_\_\_ REG. NO. 69 12670

1. NAME OF DECEASED (Type or Print) <b>JOHN McCLAIN</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> _____ M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>BON SECOURS HOSPITAL (DOA)</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>December 20, 1969 1:20 A.</b>	
6. SEX <b>Male</b>		7. RACE <b>Negro</b>	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Baltimore</b>	
9. DATE OF BIRTH <b>7/17/23</b>		10. AGE (In years last birthday) <b>46</b> If Under 1 Yr. II Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) <b>Raleigh, N. C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Truck Driver</b>		14B. KIND OF BUSINESS OR INDUSTRY	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>YES</b>		17. SOCIAL SECURITY NO.	
13. FATHER'S NAME <b>Lonnie McClain</b>		15. MOTHER'S MAIDEN NAME <b>Mozelle Mc Clain</b>	
18. INFORMANT <b>Mozell McClain; 1833 W. Vine St.; Balto., Md.</b>		ADDRESS	
19. <b>412.41</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		CAUSE OF DEATH <b>Arteriosclerotic Cardiovascular Disease</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:  (B) _____ DUE TO, OR AS A CONSEQUENCE OF:  (C) _____	
20A. DATE OF OPERATION <b>2</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (if in Baltimore City, give exact location) INJURY OCCUR?		22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>  ACTUAL SIGNATURE <b>Isidore Mihalakis, M.D.</b> M.D. EXAMINER'S NAME (Type)  CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>  DATE SIGNED <b>12/20/69</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>12/24/69</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Baltimore National Cem.</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 23 1969</b>		25B. NAME OF REGISTRAR <b>Robert E. [Signature]</b>	
25C. FUNERAL DIRECTOR <b>MORTON &amp; DYETT FUNERAL HOMES, INC.</b>		ADDRESS	

VS 151-REV. 7/1/68

1701-31 Laurens St., Balto., Md. 21217

ACADEMY BOND

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<p><b>P-450</b>      <b>69 12671</b></p> <p style="text-align: center;"><b>BALTIMORE CITY HEALTH DEPARTMENT</b></p> <p style="text-align: center;"><b>CERTIFICATE OF DEATH</b></p>		<p>REG. NO. <b>69 12671</b></p>	
<p>BIRTH NO. _____</p> <p>1. NAME OF DECEASED (Type or Print) <b>PULLEN VIRGINIA</b></p>		<p>2. DATE AND HOUR OF DEATH <b>12-21-69 7:15 P.M.</b></p>	
<p>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <b>SINAI HOSPITAL OF BALTO</b></p> <p>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)</p>		<p>4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>1608</b> C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>3813 GELSTON DR. #29</b></p>	
<p>5. SEX <b>F</b></p>	<p>6. RACE <b>N</b></p>	<p>7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p>	<p>8. DATE OF BIRTH <b>1-6-07</b> 9. AGE (in years last birthday) <b>62</b> If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.</p>
<p>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>FAMILY AID SOCIETY</b></p>		<p>10B. KIND OF BUSINESS OR INDUSTRY _____</p>	
<p>11. BIRTHPLACE (State or foreign country) <b>N.C. WARREN Co</b></p>		<p>12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b></p>	
<p>13. FATHER'S NAME <b>JAMES CLANTON</b></p>		<p>14. MOTHER'S MAIDEN NAME <b>IDA WILLIAMS</b></p>	
<p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b></p>		<p>16. SOCIAL SECURITY NO. _____</p>	<p>17. INFORMANT <b>SAMUEL Pullen, Sr.</b> ADDRESS <b>3813 Gelston Dr. #29</b></p>
<p>18. <b>75-3111</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <b>CARDIAC ARREST</b> DUE TO, OR AS A CONSEQUENCE OF: <b>CHRONIC RENAL INSUFF.</b> <b>POLYCYSTIC KIDNEY</b> <b>A.S.C.U.D.</b></p>		<p>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>YEARS</b> <b>YEARS</b> <b>YEARS</b></p>	
<p>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>II</b></p>			
<p>19A. DATE OF OPERATION <b>0</b></p>	<p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED _____</p>	<p>20A. AUTOPSY? (Yes or No) _____</p>	<p>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? _____</p>
<p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/></p>	<p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____</p>	<p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) _____</p>	
<p>21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) _____</p>	<p>21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>	<p>21F. HOW DID INJURY OCCUR? _____</p>	
<p>22. I certify that (I) (this hospital) attended the deceased from <b>12-17-69</b> to <b>12-21-69</b> that (I) (we) last saw the deceased alive on <b>12-21-69</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</p>			
<p>23A. SIGNATURE <b>9128 M.D.</b></p>		<p>23B. DATE SIGNED <b>12-21-69</b></p>	
<p>23C. PHYSICIAN'S NAME (Type) <b>CARLOS VALLEJOS M.D.</b></p>		<p>23D. ADDRESS <b>SINAI HOSP. OF BALTO</b></p>	
<p>24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b></p>	<p>24B. DATE <b>12-24-69</b></p>	<p>24C. NAME OF CEMETERY OR CREMATORY <b>Arbutus Mem PK</b></p>	<p>24D. LOCATION (City, town, or county) (State) <b>Arbutus, Md.</b></p>
<p>25A. DATE REC'D BY HEALTH DEPT. <b>DEC 23 1969</b></p>	<p>25B. NAME OF REGISTRAR <b>Robert E. [Signature]</b></p>	<p>25C. FUNERAL DIRECTOR <b>Montgomery Bye H.F.H.</b></p>	<p>ADDRESS <b>1210 17th St. N.W.</b></p>



1

W-340 69 12672 BALTIMORE CITY HEALTH DEPARTMENT

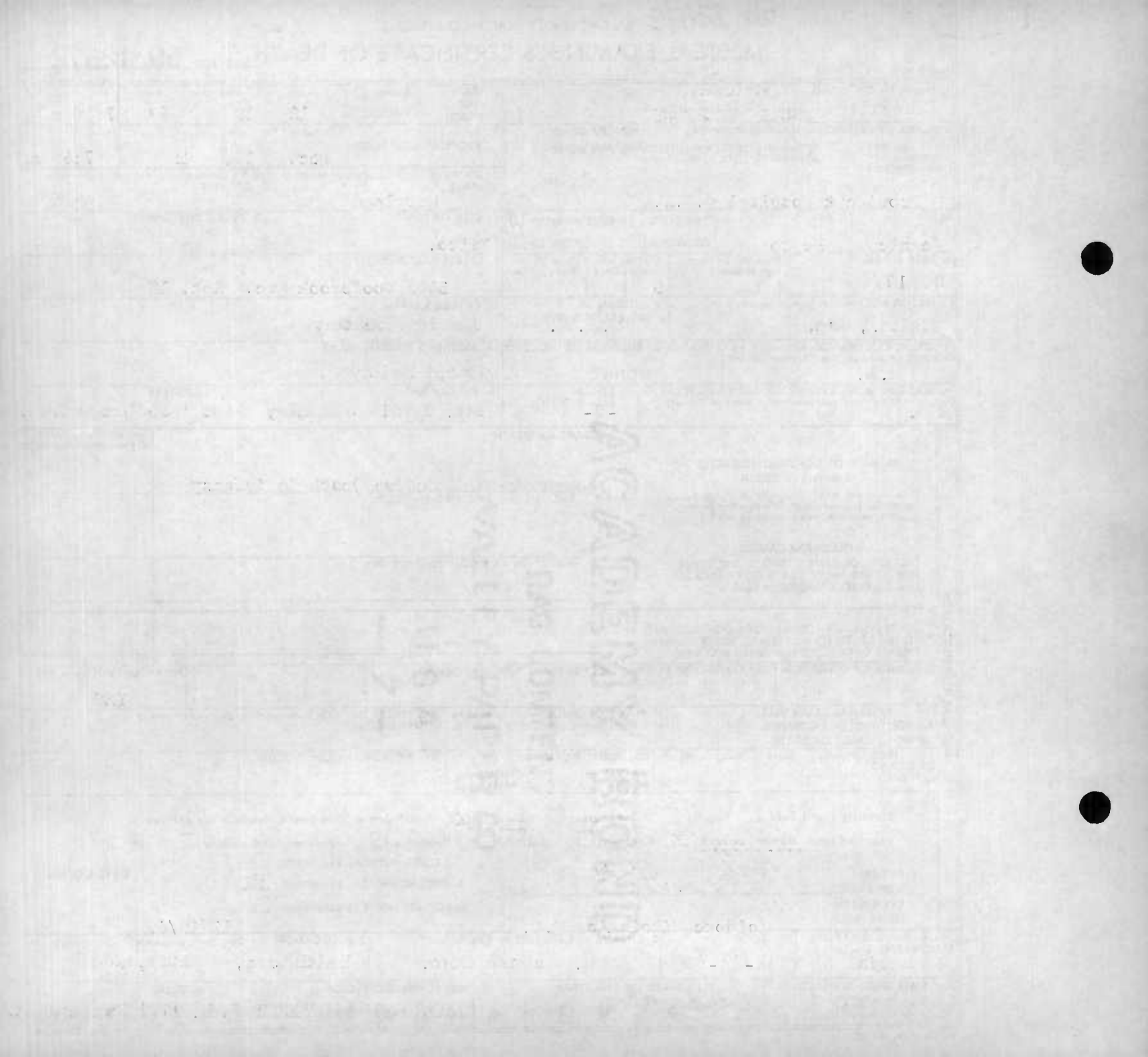
MEDICAL EXAMINER'S CERTIFICATE OF DEATH REG. NO. 69 12672

BIRTH NO. 69-17109

39  
99

1. NAME OF DECEASED (Type or Print) (Sherri) SHERI WHEATLEY		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> 12 19 69 7:40 a. M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Provident Hospital D.O.A.		3. DATE PRONOUNCED DEAD Month Day Year Dec. 19, 1969 7:40 a. M.	
6. SEX Female		7. RACE Negro	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Balto.	
9. DATE OF BIRTH 09/17/69		10. AGE (In years lost birthday) 3	
11. BIRTHPLACE (State or foreign country) Balto., Md.		12. CITIZEN OF U.S.A.	
13. FATHER'S NAME Lewis Wheatley		14. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 1304	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) n.a.		14B. KIND OF BUSINESS OR INDUSTRY none	
15. MOTHER'S MAIDEN NAME Carol Bailey		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No.	
17. SOCIAL SECURITY NO. -0-		18. INFORMANT Mr. Lewis Wheatley	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) YES			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE: [Signature] M.D. EXAMINER'S NAME (Type) Isidore Mihalakis, M.D. DATE SIGNED 12/19/69			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12-22-69	
24C. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cem.		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. DEC 23 1969		25B. NAME OF REGISTRAR Charles E. [Signature]	
25C. FUNERAL DIRECTOR MORTON & DYETT F. H.		ADDRESS 1701 Laurens St.	

VS 151-REV. 1/1/68

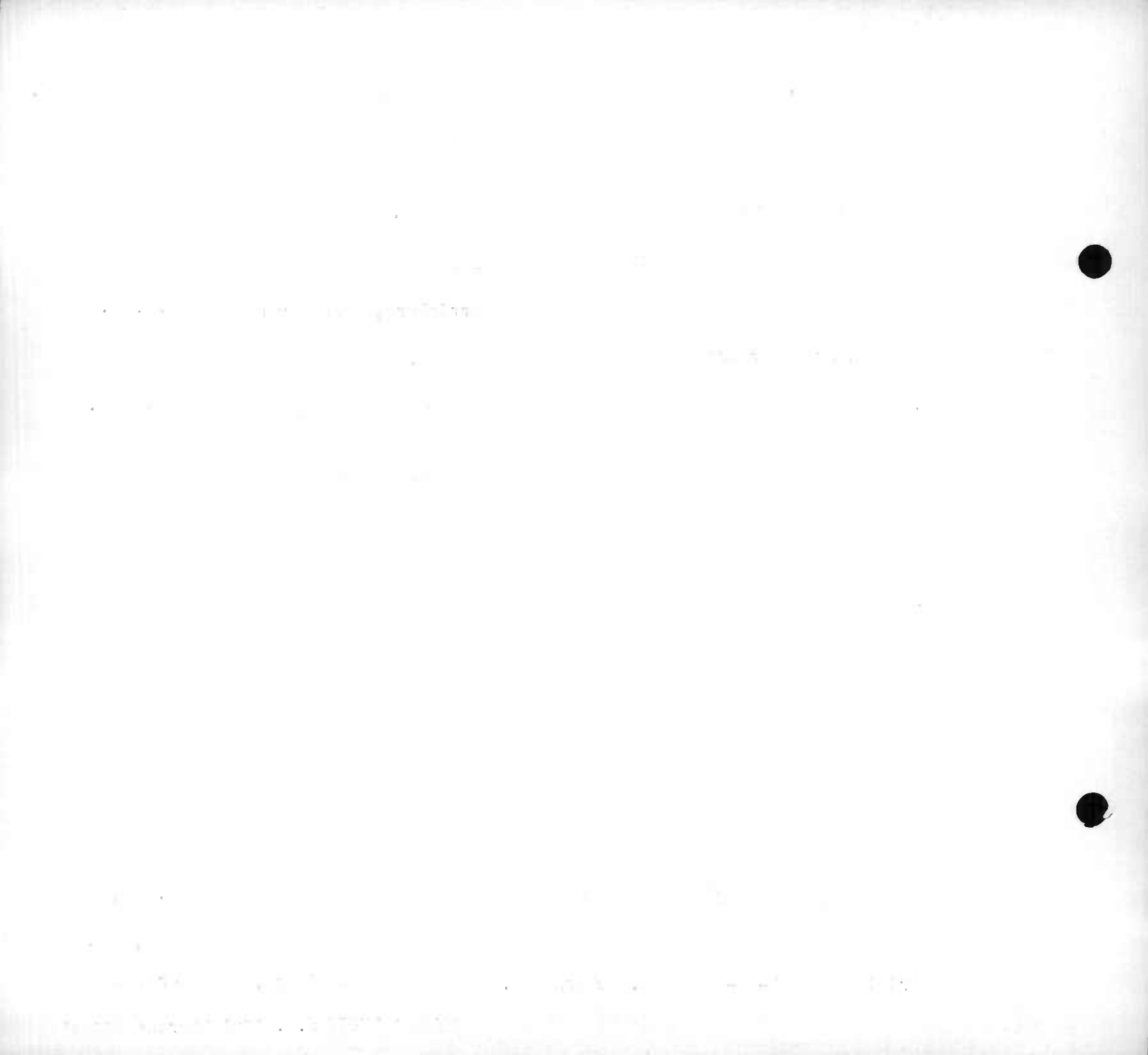




**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<p><b>B-435</b></p> <p style="font-size: 24pt;">69 12673</p>		<p>BALTIMORE CITY HEALTH DEPARTMENT</p> <p style="font-size: 24pt;">69 12673</p>	
<p><b>BIRTH NO.</b></p> <p>1. NAME OF DECEASED (Type or Print) <b>Belton, Romaine</b></p>		<p><b>2. DATE AND HOUR OF DEATH</b></p> <p><b>12-16-69</b>   <b>1:45</b> P.M.</p>	
<p><b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b></p> <p>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  <b>39</b> <b>Provident Hospital</b>  <b>1514 Divison Street</b>  <b>Baltimore, Maryland 21217</b></p>		<p><b>4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)</b></p> <p><b>A. STATE</b> <b>Maryland</b>  <b>B. COUNTY</b> <b>1302</b></p> <p><b>C. CITY OR TOWN</b> <b>Baltimore</b>  <b>D. INSIDE CITY LIMITS?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></p> <p><b>E. STREET AND NUMBER</b>  <b>2108 Mt. Royal Terr.</b></p>	
<p><b>5. SEX</b> <b>Female</b></p>	<p><b>6. RACE</b> <b>Negro</b></p>	<p><b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/>  <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/></p>	<p><b>8. DATE OF BIRTH</b> <b>9-8-10</b></p>
<p><b>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)</b> <b>None</b></p>		<p><b>9. AGE (In years last birthday)</b> <b>59</b></p>	
<p><b>10B. KIND OF BUSINESS OR INDUSTRY</b></p>		<p><b>11. BIRTHPLACE (State or foreign country)</b> <b>Harrisburg, Pennsylvania</b></p>	<p><b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S. A.</b></p>
<p><b>13. FATHER'S NAME</b> <b>George Herbert</b></p>		<p><b>14. MOTHER'S MAIDEN NAME</b> <b>Unk.</b></p>	
<p><b>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)</b> <b>No.</b></p>		<p><b>16. SOCIAL SECURITY NO.</b></p>	<p><b>17. INFORMANT ADDRESS</b> <b>Charles Scott 1918 Eutaw Pl-Newp.</b></p>
<p><b>18. CAUSE OF DEATH</b></p> <p><b>I</b></p> <p><b>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b>          (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  <b>Heart Failure</b>  <b>HEPATIC COMA</b></p> <p><b>ANTECEDENT CAUSES</b>          DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  <b>II</b></p> <p><b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</b></p>			
<p><b>19A. DATE OF OPERATION</b> <b>0</b></p>		<p><b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b></p>	
<p><b>20A. AUTOPSY? (Yes or No)</b> <b>No</b></p>		<p><b>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</b></p>	
<p><b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)</b> <input type="checkbox"/></p>		<p><b>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</b></p>	
<p><b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)</p>		<p><b>21D. TIME OF INJURY (APPROX.)</b> (Month) (Day) (Year) (Hour)</p>	
<p><b>21E. INJURY OCCURRED</b>          While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>		<p><b>21F. HOW DID INJURY OCCUR?</b></p>	
<p><b>22. I certify that (I) (this hospital) attended the deceased from <u>December 12</u> 19 <u>69</u> to <u>December 16</u> 19 <u>69</u> that (I) (we) last saw the deceased alive on <u>December 16</u> 19 <u>69</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</b></p>			
<p><b>23A. SIGNATURE</b> <i>George Herbert</i></p>		<p><b>23B. DATE SIGNED</b> <b>Dec. 16, 1969</b></p>	
<p><b>23C. PHYSICIAN'S NAME (Type)</b> <b>G. Tenor</b></p>		<p><b>23D. ADDRESS</b> <b>1514 Divison Street Baltimore, Md.</b></p>	
<p><b>24A. BURIAL CREMATION, REMOVAL (Specify)</b> <b>Burial</b></p>	<p><b>24B. DATE</b> <b>12-20-69</b></p>	<p><b>24C. NAME OF CEMETERY OR CREMATORY</b> <b>Mt. Auburn Cem.</b></p>	<p><b>24D. LOCATION (City, town, or county) (State)</b> <b>Baltimore, Maryland</b></p>
<p><b>25A. DATE REC'D BY HEALTH DEPT.</b> <b>DEC 23 1969</b></p>		<p><b>25B. NAME OF REGISTRAR</b> <b>Robert E. Jackson</b></p>	
<p><b>25C. FUNERAL DIRECTOR ADDRESS</b> <b>MORTON &amp; DYETT F.H. 1701 Laurens Street</b></p>			

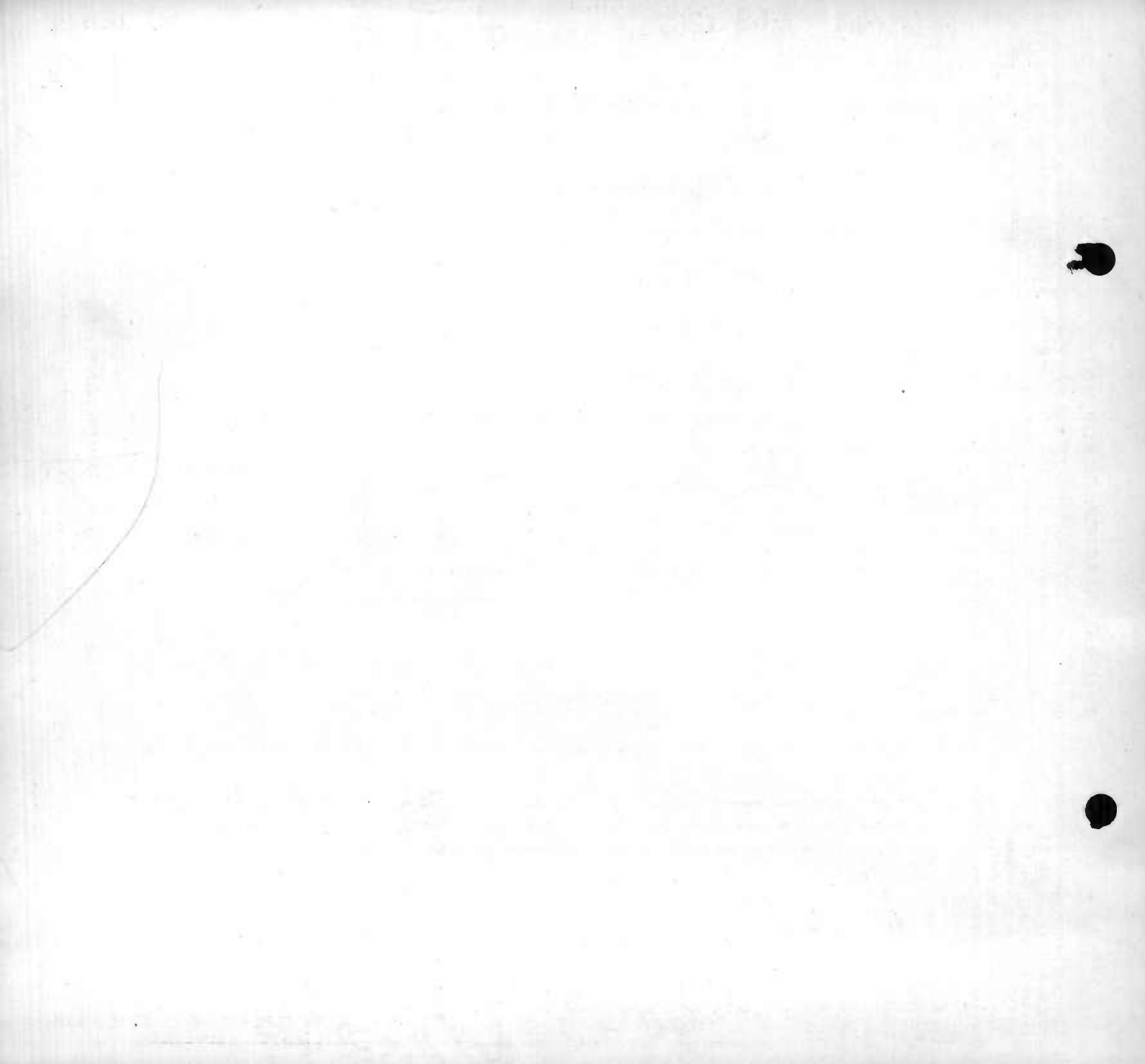




# FUNERAL DIRECTOR: IMPORTANT

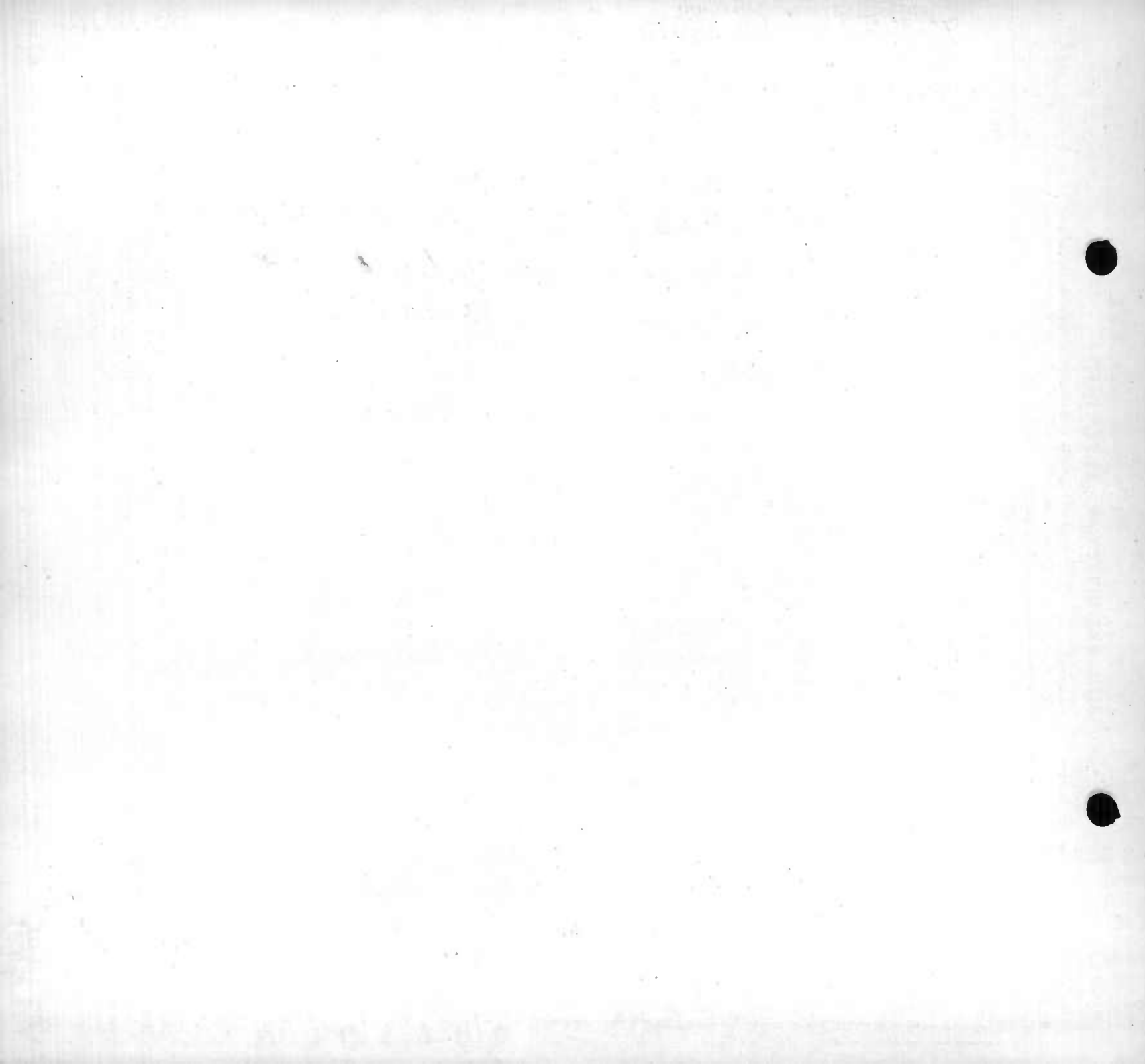
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

G-120 69 12674 BIRTH NO. 67-24876		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 69 12674	
1. NAME OF DECEASED (Type or Print) SHAWN GIBBS		2. DATE AND HOUR OF DEATH 12/21/69 - 2 15 AM M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 33 THE JOHNS HOPKINS HOSPITAL		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE CITY 1547 C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES XX NO <input type="checkbox"/> E. STREET AND NUMBER 2948 CLIFTON AVENUE 21216			
5. SEX MALE	6. RACE NEGRO	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-8-67	9. AGE (In years last birthday) 2	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) n/a		10B. KIND OF BUSINESS OR INDUSTRY n/a		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME DONALD GIBBS		14. MOTHER'S MAIDEN NAME VERNA LEWIS	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) N/A		16. SOCIAL SECURITY NO. N/A		17. INFORMANT Donald Gibbs	
18. 35-7, 91 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE Aspiration pneumonia DUE TO, OR AS A CONSEQUENCE OF: (B) Peripheral motor neuropathy DUE TO, OR AS A CONSEQUENCE OF: of unknown etiology (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days 3 months	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from December 18 19 69 to Dec 21 19 69 that (I) (we) last saw the deceased alive on Dec 21 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE Gary Rakchelsky		23B. DATE SIGNED 12/21/69		23C. PHYSICIAN'S NAME (Type) GARY RAKCHELSKY	
23D. ADDRESS Johns Hopkins Hospital					
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 12/24/69		24C. NAME OF CEMETERY OR CREMATORY Baltimore National Cem.	
24D. LOCATION Baltimore, Maryland					
25A. DATE REC'D BY HEALTH DEPT. DEC 23 1969		25B. NAME OF REGISTRAR E. J. [unclear]		25C. FUNERAL DIRECTOR MORTON & DYETT FUNERAL HOME 1701 Laurens	
25D. ADDRESS Baltimore, Maryland					



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

VS 150-REV. 1/1/6B



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <b>13-423</b>		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. <b>69 12676</b>	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>CLARENCE BLACKDEN</b>		2. DATE AND HOUR OF DEATH <b>December 19, 1969</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>46 LUTHERAN HOSPITAL</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>1608</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b> D. STREET ADDRESS (If rural, give location) <b>3805 Gelston Drive</b>			
5. SEX <b>Male</b>	6. RACE <b>Negro</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>Married</b>	8. DATE OF BIRTH <b>6-5-1900</b>	9. AGE (In years last birthday) <b>69</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Merchant Marine</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>New Zealand</b>	12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>
13. FATHER'S NAME <b>Adfred Blackden</b>			14. MOTHER'S MAIDEN NAME <b>Eva Blackden</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No.</b>		16. SOCIAL SECURITY NO. <b>217-14-0682</b>		17. INFORMANT ADDRESS <b>Mrs. Pearl Blackden 3805 Gelston Drive</b>	
18. <b>441.91</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <b>RESPIRATORY FAILURE</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>AORTIC ANEURYSM RUPTURE</b> <b>Hypertension &amp; Arteriosclerotic CUR disease</b>		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>1968</b> to <b>1969</b> that (I) (we) last saw the deceased alive on <b>1968</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death.					
23A. SIGNATURE <b>J. Shorofsky</b>				23B. DATE SIGNED <b>12/23/69</b>	
23C. PHYSICIAN'S NAME (Type) <b>S. Borofsky</b>				23D. ADDRESS <b>4734 PARK Ht. Baltimore, Md</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12-23-69</b>		24C. NAME OF CEMETERY or CREMATORY <b>New Cathedral Cem.</b>	
24D. LOCATION <b>Baltimore, Maryland</b>		25A. DATE REC'D BY HEALTH DEPT. <b>DEC 23 1969</b>			
25B. NAME OF REGISTRAR <b>Robert E. Taylor, M.D.</b>		25C. FUNERAL DIRECTOR ADDRESS <b>MORTON &amp; DYETT F.H. 1701 Laurens St.</b>			

Received for

the sum of

Five hundred and

100

100

100

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## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <u>X-532</u>				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <u>69 12677</u>	
1. NAME OF DECEASED (Type or Print) <u>Steve (Stefanos) Xintas</u>				2. DATE AND HOUR OF DEATH <u>12/15/69</u> <u>11 45 P</u> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>31</u>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Baltimore City Hospital</u> <u>4940 Eastern Avenue</u> <u>Baltimore, Md. 21224</u>		A. STATE <u>Maryland</u>		B. COUNTY <u>2605</u>	
5. SEX <u>Male</u>				6. RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	
8. DATE OF BIRTH <u>8-20-04</u>		9. AGE (In years last birthday) <u>65</u>		10. UNDER 1 Yr. Months Days		11. UNDER 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Owner - Grocery</u>				10B. KIND OF BUSINESS OR INDUSTRY <u>Food</u>		11. BIRTHPLACE (State or foreign country) <u>Greece</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>Constantine</u>			
14. MOTHER'S MAIDEN NAME <u>Marie</u>				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>			
16. SOCIAL SECURITY NO. <u>232-03-4523</u>				17. INFORMANT <u>4940 Eastern Avenue</u> <u>BCH Records: Baltimore, Md. 21224</u>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>acute myocardial infarct</u>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>8 hrs.</u>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last <u>(B) pneumothorax</u>				(C) _____			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>(D) pneumothorax</u>				_____			
19A. DATE OF OPERATION <u>12/15/69</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>(E) Pneumothorax</u>		20A. AUTOPSY? (Yes or No) <u>Yes</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>YES</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input checked="" type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>street</u>		21C. WHERE DID INJURY OCCUR? <u>?</u>		(If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) <u>12 15 1969 ?</u>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? <u>pt. fell + broke rib</u>			
22. I certify that (A) (this hospital) attended the deceased from <u>12/15</u> 19 <u>69</u> to <u>12/15</u> 19 <u>69</u> that (B) (we) last saw the deceased alive on <u>12/15</u> 19 <u>69</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (C) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Lynne I. Neefe M.D.</u>				23B. DATE SIGNED <u>12/15/69</u>		23C. PHYSICIAN'S NAME (Type) <u>Lynne I. Neefe, M.D.</u>	
23D. ADDRESS <u>4940 Eastern Ave.</u> <u>c/o Balto. City Hosps. Balto., Md. 21224</u>		24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>					
24B. DATE <u>12-18-69</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Greek Orthodox Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>DEC 23 1969</u>		25B. NAME OF REGISTRAR <u>Robert E. Nalley, M.D.</u>		25C. FUNERAL DIRECTOR <u>Nicholas T. Matthews</u>		ADDRESS <u>2014 Eastern Ave., Baltimore, Md.</u>	





This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

69 12678

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

REG. NO. 69 12678

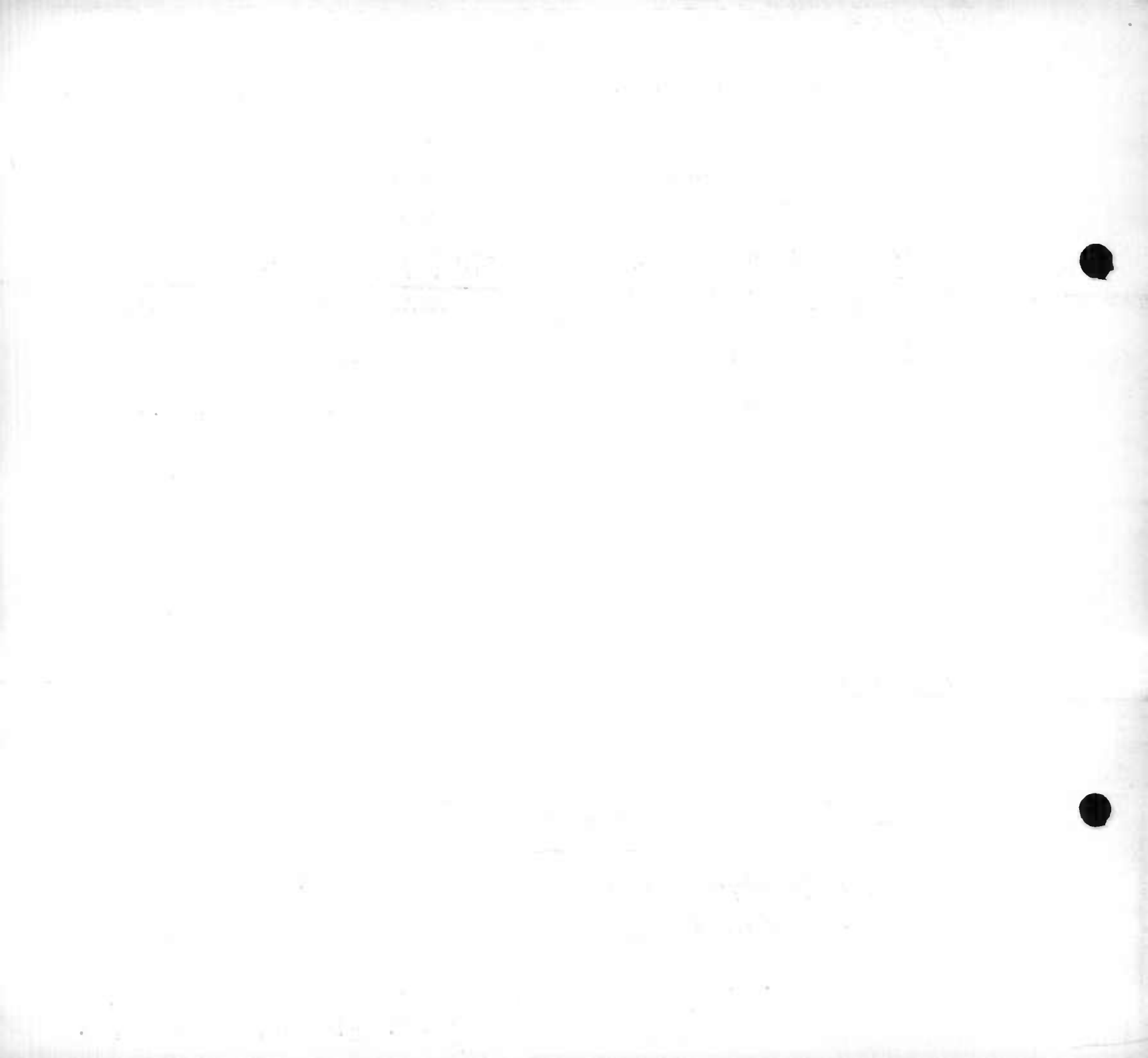
BIRTH NO. 69 12678		1. NAME OF DECEASED (Type or Print) <b>MARTHA M SIMMONS</b>		2. DATE AND HOUR OF DEATH <b>November 11, 1969</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>2833</b>			
FULL NAME OF HOSPITAL OR INSTITUTION <b>00</b>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>5213 Windsor Mill Road</b>		C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <b>Female</b> 6. RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>5-1-1895</b> 9. AGE (In years last birthday) <b>74 yrs.</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clerk</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>William Muth</b>		14. MOTHER'S MAIDEN NAME <b>Wallace</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <b>Donald E. Simmons-5215 Windsor Mill Rd.</b>	
MEDICAL CERTIFICATION (18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>4123 I</b> CORONARY HEART DISEASE (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: CORONARY ARTEROSCLEROSIS (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____ ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART (A). <b>NONE</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 Yrs.</b>			
		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 Yrs.</b>			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notably medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>4-8</b> 19 <b>65</b> to <b>11-11</b> 19 <b>69</b> that (I) (we) last saw the deceased alive on <b>10-15</b> 19 <b>69</b> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Leon Ashman M.D.</i>				23B. DATE SIGNED <b>12-13-69</b>	
23C. PHYSICIAN'S NAME (Type) <b>Dr. Leon Ashman</b>				23D. ADDRESS <b>5907 Gwynn Oak Ave.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>11-14-69</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Lorraine Cemetery</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>					
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 24 1969</b>		25B. NAME OF REGISTRAR <i>Robert E. Taylor, M.D.</i>		25C. FUNERAL DIRECTOR ADDRESS <b>Annacost Funeral Chapel 4600 Liberty Hghts.</b>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<p><b>BIRTH NO.</b> <span style="font-size: 1.5em;">L-263</span> <span style="font-size: 1.5em;">69 12679</span></p>		<p><b>BALTIMORE CITY HEALTH DEPARTMENT</b></p>		<p><b>CERTIFICATE OF DEATH</b></p>		<p><b>X REG. NO.</b> <span style="font-size: 1.5em;">69 12679</span></p>	
<p><b>1. NAME OF DECEASED</b> (Type or Print) <span style="font-size: 1.2em;">James La Gratta</span></p>				<p><b>2. DATE AND HOUR OF DEATH</b> <span style="font-size: 1.2em;">12/17/1969 5<sup>00</sup> A M.</span></p>			
<p><b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b></p>				<p><b>4. USUAL RESIDENCE</b> (Where deceased lived, if institution; residence before admission) A. STATE <span style="font-size: 1.2em;">Maryland</span> B. COUNTY <span style="font-size: 1.2em;">Baltimore</span></p>			
<p><b>FULL NAME OF HOSPITAL OR INSTITUTION</b> (If not in hospital or institution, give street address or location) <span style="font-size: 1.2em;">UNIV. of Maryland 38 Hospital</span></p>				<p><b>C. CITY OR TOWN</b> <span style="font-size: 1.2em;">Baltimore</span></p>		<p><b>D. INSIDE CITY LIMITS?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></p>	
				<p><b>E. STREET AND NUMBER</b> <span style="font-size: 1.2em;">3520 Annapolis Rd.</span></p>			
<p><b>5. SEX</b> <span style="font-size: 1.2em;">M.</span></p>	<p><b>6. RACE</b> <span style="font-size: 1.2em;">White</span></p>	<p><b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/></p>	<p><b>8. DATE OF BIRTH</b> <span style="font-size: 1.2em;">2/17/17</span></p>	<p><b>9. AGE</b> (In years last birthday) <span style="font-size: 1.2em;">52</span></p>	<p><b>10. Under 1 Yr.</b> Months <span style="font-size: 1.2em;">11</span> Days <span style="font-size: 1.2em;">17</span> Hours <span style="font-size: 1.2em;">17</span> Min.</p>	<p><b>11. BIRTHPLACE</b> (State or foreign country) <span style="font-size: 1.2em;">Maryland</span></p>	
<p><b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">Plumber</span></p>				<p><b>10B. KIND OF BUSINESS OR INDUSTRY</b> <span style="font-size: 1.2em;">Hospital</span></p>		<p><b>12. CITIZEN OF WHAT COUNTRY?</b> <span style="font-size: 1.2em;">USA</span></p>	
<p><b>13. FATHER'S NAME</b> <span style="font-size: 1.2em;">Joseph La Gratta (Orazio)</span></p>				<p><b>14. MOTHER'S MAIDEN NAME</b> <span style="font-size: 1.2em;">Lena Laserra</span></p>			
<p><b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service) Yes <span style="font-size: 1.2em;">War II-Navy</span></p>				<p><b>16. SOCIAL SECURITY NO.</b></p>		<p><b>17. INFORMANT ADDRESS</b> <span style="font-size: 1.2em;">James Lagratta, Cumberland, Md. - Son</span></p>	
<p><b>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <span style="font-size: 1.2em;">11/30/69</span></p>				<p><b>CAUSE OF DEATH</b></p>			
<p><b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p>				<p>(A) IMMEDIATE CAUSE <span style="font-size: 1.2em;">MASSIVE TRACHEAL hemorrhage</span> DUE TO, OR AS A CONSEQUENCE OF: <span style="font-size: 1.2em;">Broncho pleural fistula</span></p>			
				<p>(B) <span style="font-size: 1.2em;">Aspiration Pneumonia - Acetabulopneumonia</span> DUE TO, OR AS A CONSEQUENCE OF:</p>			
				<p>(C) <span style="font-size: 1.2em;">Aspiration Pneumonia - Acetabulopneumonia</span></p>			
<p><b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</b></p>							
<p><b>19A. DATE OF OPERATION</b> <span style="font-size: 1.2em;">Dec 1-69</span></p>		<p><b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b> <span style="font-size: 1.2em;">Chronic lung Abscesses</span></p>		<p><b>20A. AUTOPSY?</b> (Yes or No) <input type="checkbox"/></p>		<p><b>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</b></p>	
<p><b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner) <input type="checkbox"/></p>		<p><b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>		<p><b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)</p>			
<p><b>21D. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (APPROX.)</p>		<p><b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>		<p><b>21F. HOW DID INJURY OCCUR?</b></p>			
<p><b>22. I certify that (I) (this hospital) attended the deceased from <span style="font-size: 1.2em;">11/10/69</span> to <span style="font-size: 1.2em;">Dec. 17/69</span> that (I) (we) last saw the deceased alive on <span style="font-size: 1.2em;">Dec. 17/69</span> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</b></p>							
<p><b>23A. SIGNATURE</b> <span style="font-size: 1.2em;">James F. Scarpelli M.D.</span></p>				<p><b>Attending Phys.</b> <input type="checkbox"/> <b>Med. Director</b> <input type="checkbox"/> <b>Staff Phys.</b> <input checked="" type="checkbox"/></p>		<p><b>23B. DATE SIGNED</b> <span style="font-size: 1.2em;">Dec 17-69</span></p>	
<p><b>23C. PHYSICIAN'S NAME</b> (Type) <span style="font-size: 1.2em;">J.M. Blackford M.D.</span></p>				<p><b>23D. ADDRESS</b> <span style="font-size: 1.2em;">UNIV. MD. HOSPITAL</span></p>			
<p><b>24A. BURIAL CREMATION, REMOVAL</b> (Specify) <span style="font-size: 1.2em;">Burial</span></p>		<p><b>24B. DATE</b> <span style="font-size: 1.2em;">Dec. 20, 1969</span></p>		<p><b>24C. NAME of CEMETERY or CREMATORY</b> <span style="font-size: 1.2em;">Davis Memorial Cemetery</span></p>		<p><b>24D. LOCATION</b> (City, town, or county) (State) <span style="font-size: 1.2em;">Cumberland, Allegany, Md.</span></p>	
<p><b>25A. DATE REC'D BY HEALTH DEPT.</b> <span style="font-size: 1.2em;">DEC 24 1969</span></p>		<p><b>25B. NAME OF REGISTRAR</b> <span style="font-size: 1.2em;">Robert E. Talley, M.D.</span></p>		<p><b>25C. FUNERAL DIRECTOR ADDRESS</b> <span style="font-size: 1.2em;">James F. Scarpelli, Cumberland, Md.</span></p>			



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

69 12680

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>STANLEY M. Kirchenbauer</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>SOUTH BALTO. GENERAL HOSPITAL (DOA)</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>December 20, 1969 8:05 P.</b>	
5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>2505</b>		C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
6. SEX <b>Male</b>	7. RACE <b>White</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH <b>1/23/89</b>		10. AGE (In years last birthday) <b>80</b> If Under 1 Yr. II Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF <b>WHAT COUNTRY?</b>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Shipfitter</b>		14B. KIND OF BUSINESS OR INDUSTRY <b>U. S. Coast Guard</b>	
15. MOTHER'S MAIDEN NAME <b>Mary Tyhe</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or doles of service) <b>No</b>	
17. SOCIAL SECURITY NO.		18. INFORMANT <b>Mr. Stanley H. Kirchenbauer</b> ADDRESS <b>21226 1623 Locust St.</b>	
19. <b>412.4 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Arteriosclerotic Cardiovascular Disease</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>(A) IMMEDIATE CAUSE</b> DUE TO, OR AS A CONSEQUENCE OF: <b>(B) DUE TO, OR AS A CONSEQUENCE OF:</b> <b>(C) DUE TO, OR AS A CONSEQUENCE OF:</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <b>Isidore Mihalakis, M.D.</b> CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) <b>Isidore Mihalakis, M.D.</b> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>12/21/69</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12/24/69</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Cedar Hill</b>		24D. LOCATION (City, town, or county) (State) <b>Ritchie Highway A. A. Co. Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 24 1969</b>		25B. NAME OF REGISTRAR <b>Robert E. Tolson, M.D.</b>	
25C. FUNERAL DIRECTOR <b>M. E. Kelly</b>		ADDRESS <b>237 Patapsco Ave. 21225</b>	

WATER PROOFED  
ACADEMIC BOND

J-520 69 12681				BALTIMORE CITY HEALTH DEPARTMENT			
MEDICAL EXAMINER'S CERTIFICATE OF DEATH				REG. NO. 69 12681			
BIRTH NO.							
1. NAME OF DECEASED (Type or Print) ERNEST G. JONES				2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> December 17, 1969			
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 5407 Belle Vista				3. DATE PRONOUNCED DEAD Month Day Year December 17, 1969 1:15 P.M.			
6. SEX Male				7. RACE White		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH February 7, 1920 49				10. AGE (In years last birthday)		11. BIRTHPLACE (State or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? USA				13. FATHER'S NAME Henry C. Jones		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electrician-ret.	
15. MOTHER'S MAIDEN NAME Leona Pierce				16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give year or dates of service) Yes		17. SOCIAL SECURITY NO. 214-22-2598	
18. INFORMANT Family records				ADDRESS			
19. CAUSE OF DEATH E966 X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				(A) IMMEDIATE CAUSE Stabbwound of chest DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:			
20A. DATE OF OPERATION				20B. CONDITION FOR WHICH OPERATION WAS PERFORMED			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home			
22C. WHERE DID INJURY OCCUR? 5407 Belle Vista				22D. TIME OF INJURY (APPROX.) 12-17-69			
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				22F. HOW DID INJURY OCCUR? Stabbed during altercation			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Charles S. Springgate, M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type)				ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial				24B. DATE Dec. 20, 1969			
24C. NAME OF CEMETERY or CREMATORY Glynmalare Cemetery				24D. LOCATION (City, town, or county) (State) Monkton, Maryland			
25A. DATE REC'D BY HEALTH DEPT. DEC 24 1969				25B. NAME OF REGISTRAR Robert E. Taylor, M.D.			
25C. FUNERAL DIRECTOR John Burns & Sons, Towson, Maryland				ADDRESS			



ACADEMY



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

U-256		69 12682		BALTIMORE CITY HEALTH DEPARTMENT		X		REG. NO.		69 12682	
BIRTH NO.						1. NAME OF DECEASED (Type or Print) <i>Leonard A. Wagner, Sr.</i>					
2. DATE AND HOUR OF DEATH <i>December 19, 1969 10 A.M.</i>						3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD					
FULL NAME OF HOSPITAL OR INSTITUTION <i>THE JOHNS HOPKINS HOSPITAL</i> <i>33</i>						(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)					
4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>ANNE ARUNDEL</i> <i>52-00</i>						C. CITY OR TOWN <i>Gambrills</i>					
D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						E. STREET AND NUMBER <i>Waugh Chapel Road</i>					
5. SEX <i>Male</i>		6. RACE <i>Caucasian</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>8/15/21</i>		9. AGE (In years last birthday) <i>48</i>		If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Drywell</i>				10B. KIND OF BUSINESS OR INDUSTRY <i>OWNER</i>				11. BIRTHPLACE (State or foreign country) <i>Severn, Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>James Wagner</i>						14. MOTHER'S MAIDEN NAME <i>Esther Peterson</i>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>Yes</i> <i>II</i>				16. SOCIAL SECURITY NO. <i>214-12-7577</i>		17. INFORMANT <i>Lorraine T. Wagner</i> <i>Sams (4a-e)</i>					
18. <i>162.1</i> I CAUSE OF DEATH						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>Disseminated bronchogenic oat cell carcinoma.</i>						<i>3 months</i>					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:											
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <i>NONE</i>											
19A. DATE OF OPERATION <i>NONE</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>NONE</i>		20A. AUTOPSY? (Yes or No) <i>NO</i> <i>YES</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <i>NO</i>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) <i>NONE</i>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <i>NONE</i>							
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <i>NONE</i>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?							
22. I certify that (I) (this hospital) attended the deceased from <i>December 10, 1969</i> to <i>December 19, 1969</i> , that (I) (we) last saw the deceased alive on <i>December 19, 1969</i> and that in (my) <i>own</i> opinion death occurred on the date and hour and from the causes stated above. (I) <i>(we)</i> (did) <i>(did not)</i> view the body after death.											
23A. SIGNATURE <i>James W. Forster, M.D.</i> DEGREE						Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>December 19, 1969</i>			
23C. PHYSICIAN'S NAME (Type) <i>James W. Forster, M.D.</i> DEGREE						23D. ADDRESS <i>JOHNS HOPKINS HOSPITAL</i>					
24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i>		24B. DATE <i>Dec 22, 1969</i>		24C. NAME of CEMETERY or CREMATORY <i>H. H. Crest</i>		24D. LOCATION (City, town, or county) (State) <i>ANNAPOLIS, AA, MD.</i>					
25A. DATE REC'D BY HEALTH DEPT. <i>DEC 24 1969</i>		25B. NAME OF REGISTRAR <i>Robert E. Taylor, M.D.</i>		25C. FUNERAL DIRECTOR <i>Wm. J. Bell, Jr.</i>		25D. ADDRESS <i>Appony Funeral Home</i>					



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

C-500		BALTIMORE CITY HEALTH DEPARTMENT		69 12683	
BIRTH NO.		<b>CERTIFICATE OF DEATH</b>		REG. NO. <span style="float: right;">69 12683</span>	
1. NAME OF DECEASED (Type or Print) <u>CHANEY, MARGARET LUCILLE</u>		2. DATE AND HOUR OF DEATH <u>12/21/69</u> <u>11:20</u> P. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>38 UNIVERSITY HOSPITAL</u>		A. STATE <u>MARYLAND</u>		B. COUNTY <u>ANNAPOLIS</u>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <u>Millersville</u>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
		E. STREET AND NUMBER <u>P.O. Box 35 Millersville Rd.</u>			
5. SEX <u>F</u>	6. RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4/20/27</u>	9. AGE (In years last birthday) <u>42</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Book Keeper</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Paper Supply</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
13. FATHER'S NAME <u>Lloyd G. Gross</u>		14. MOTHER'S MAIDEN NAME <u>ELLA LEE BOTTEWILL</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>216-20-5161</u>		17. INFORMANT <u>Hospital CHART</u>	
18. <u>205.141250.9</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>DIABETES MELLITUS</u>		CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>PSEUDOMONAS SEPTICEMIA</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>CHRONIC MYELOBLASTIC LEUKEMIA</u> DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 Days</u> <u>6 months</u> <u>9 months</u>	
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>YES</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>10/16</u> 19 <u>69</u> to <u>12/21</u> 19 <u>69</u> that (I) (we) last saw the deceased alive on <u>12/21</u> 19 <u>69</u> and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Barbara Brautman M.D.</u>				23B. DATE SIGNED <u>12/21/69</u>	
23C. PHYSICIAN'S NAME (Type) <u>BARBARA BRAUTMAN M.D.</u>				23D. ADDRESS <u>UNIVERSITY HOSPITAL BALTO, MD.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>Dec. 24, 69</u>		24C. NAME OF CEMETERY OR CREMATORY <u>St. Stephens</u>	
24D. LOCATION (City, town, or county) (State) <u>Gary Brills A.A., MD.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>DEC 24 1969</u>			
25B. NAME OF REGISTRAR <u>Robert E. Taylor</u>		25C. FUNERAL DIRECTOR <u>Charles F. Bell, Jr. (Chas. F. Bell, Jr.)</u>			
25D. ADDRESS <u>Dropping Funeral Home ANNAPOLIS, MD.</u>					



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

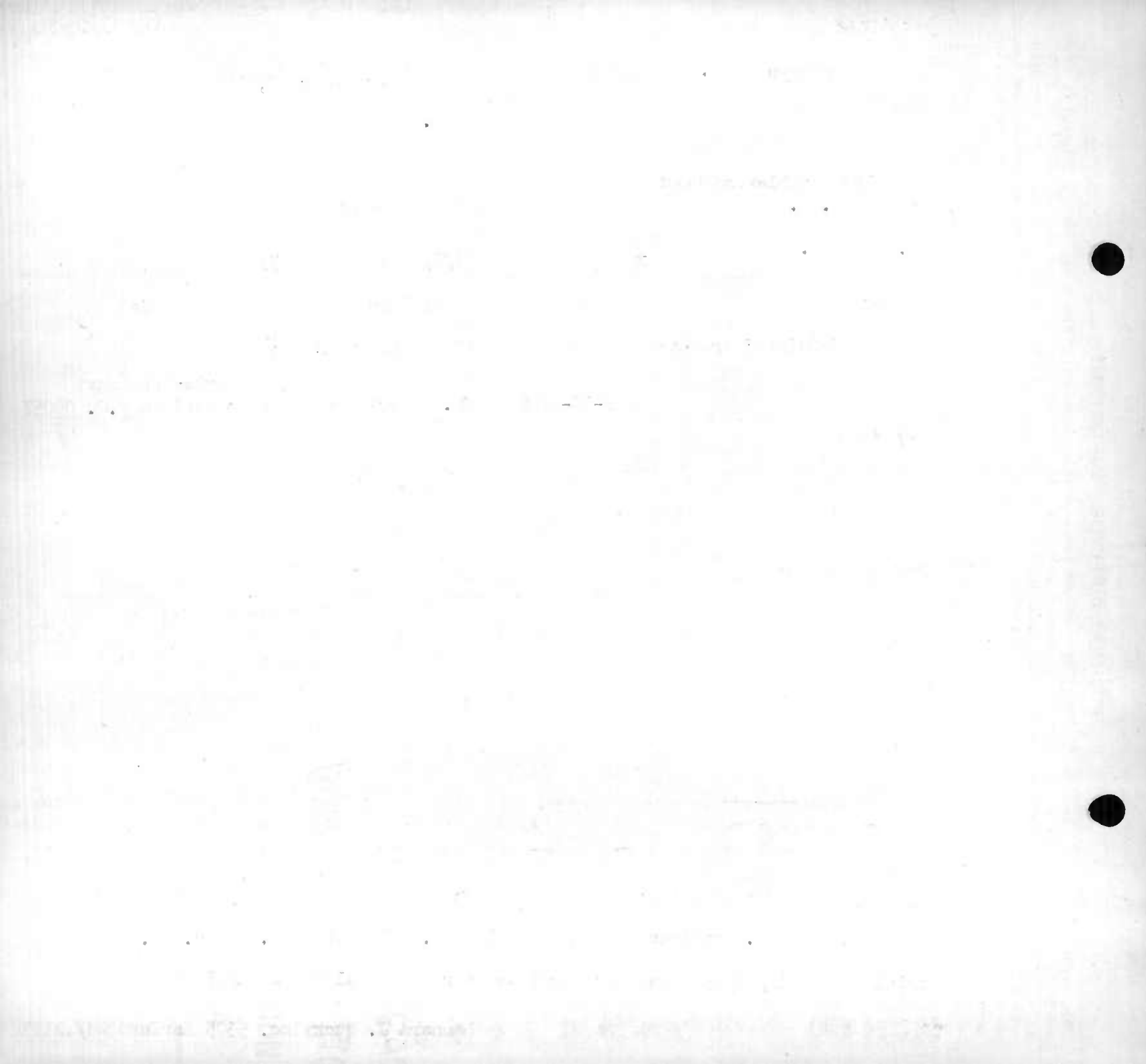
<div style="display: flex; justify-content: space-between;"> <span><b>E-250</b></span> <span><b>69 12684</b></span> <span>BALTIMORE CITY HEALTH DEPARTMENT</span> </div>		<b>CERTIFICATE OF DEATH</b>		REG. NO. <b>69 12684</b>	
BIRTH NO. _____					
1. NAME OF DECEASED (Type or Print) <b>James G Esson</b>			2. DATE AND HOUR OF DEATH <b>December 21, 1969</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>1526 Sheffield Road</b>			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>2759</b> C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>1526 Sheffield Road</b>		
5. SEX <b>Male</b>		6. RACE <b>Caucasian</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <b>Feb 1, 1886</b>		9. AGE (In years last birthday) <b>83</b>		If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Horticulturist Retired</b>			10B. KIND OF BUSINESS OR INDUSTRY _____		
11. BIRTHPLACE (State or foreign country) <b>Scotland</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>James Esson</b>			14. MOTHER'S MAIDEN NAME <b>Isabelle Gray</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>076-20-7029A</b>		17. INFORMANT <b>Mrs Jean Esson</b>	
ADDRESS _____		ADDRESS _____		ADDRESS _____	
18. <b>410.9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <i>Myocardial Infarction</i> (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____					
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH _____					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). _____					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED _____		20A. AUTOPSY? (Yes or No) <b>No</b>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? _____		(If in Baltimore City, give exact location) _____			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21C. WHERE DID INJURY OCCUR? _____	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) _____		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? _____	
22. I certify that (1) (this hospital) attended the deceased from <b>DEC 18 1969</b> to <b>DEC 21 1969</b> , that (1) (we) last saw the deceased alive on <b>12/11 1969</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>William M. Smith M.D.</i>				23B. DATE SIGNED <b>12/23/69</b>	
23C. PHYSICIAN'S NAME (Type) <b>William M. Smith M.D.</b>				23D. ADDRESS <b>6305 The Alameda Baltimore Maryland</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12/23/69</b>		24C. NAME OF CEMETERY or CREMATORY <b>Parkwood</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland 21234</b>		25A. DATE REC'D BY HEALTH DEPT. <b>DEC 24 1969</b>			
25B. NAME OF REGISTRAR <b>Robert E. Taylor, M.D.</b>		25C. FUNERAL DIRECTOR <b>Leonard J. Ryck Inc. 5305 Harford Rd. 21214</b>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.	69 12685
S-150		69 12685		CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) Kathryn G. Spann		2. DATE AND HOUR OF DEATH December 20, 1969	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION  1900 Ramblewood Road Apt. B.		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY  C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  E. STREET AND NUMBER 1900 Ramblewood Road			
5. SEX F.	6. RACE W.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/3/1890	9. AGE (In years last birthday) 79	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Ferdinand Trenkamp		14. MOTHER'S MAIDEN NAME Mary Kettleroy	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 219-30-9549		17. INFORMANT ADDRESS Charleston Court Mr. Robert Spann 532 Moorestown N.J. 08057	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.)  DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Coronary occlusion (B) DUE TO, OR AS A CONSEQUENCE OF: A.S.C.V.D. (C) DUE TO, OR AS A CONSEQUENCE OF: Scurvy		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 1947 to Jan 18 1969, that (I) (we) last saw the deceased alive on Jan 15 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE Theodore J. Graziano		23B. DATE SIGNED 12/22/69		23C. PHYSICIAN'S NAME (Type) Theodore J. Graziano MD	
23D. ADDRESS 1654 E. Belvedere Ave. Balto. Md.		24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/23/69	
24C. NAME OF CEMETERY or CREMATORY New Cathedral Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore Maryland		25A. DATE REC'D BY HEALTH DEPT. DEC 24 1969	
25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Leonard J. Huck Inc.		25D. ADDRESS 5305 Harford Rd/ 21214	

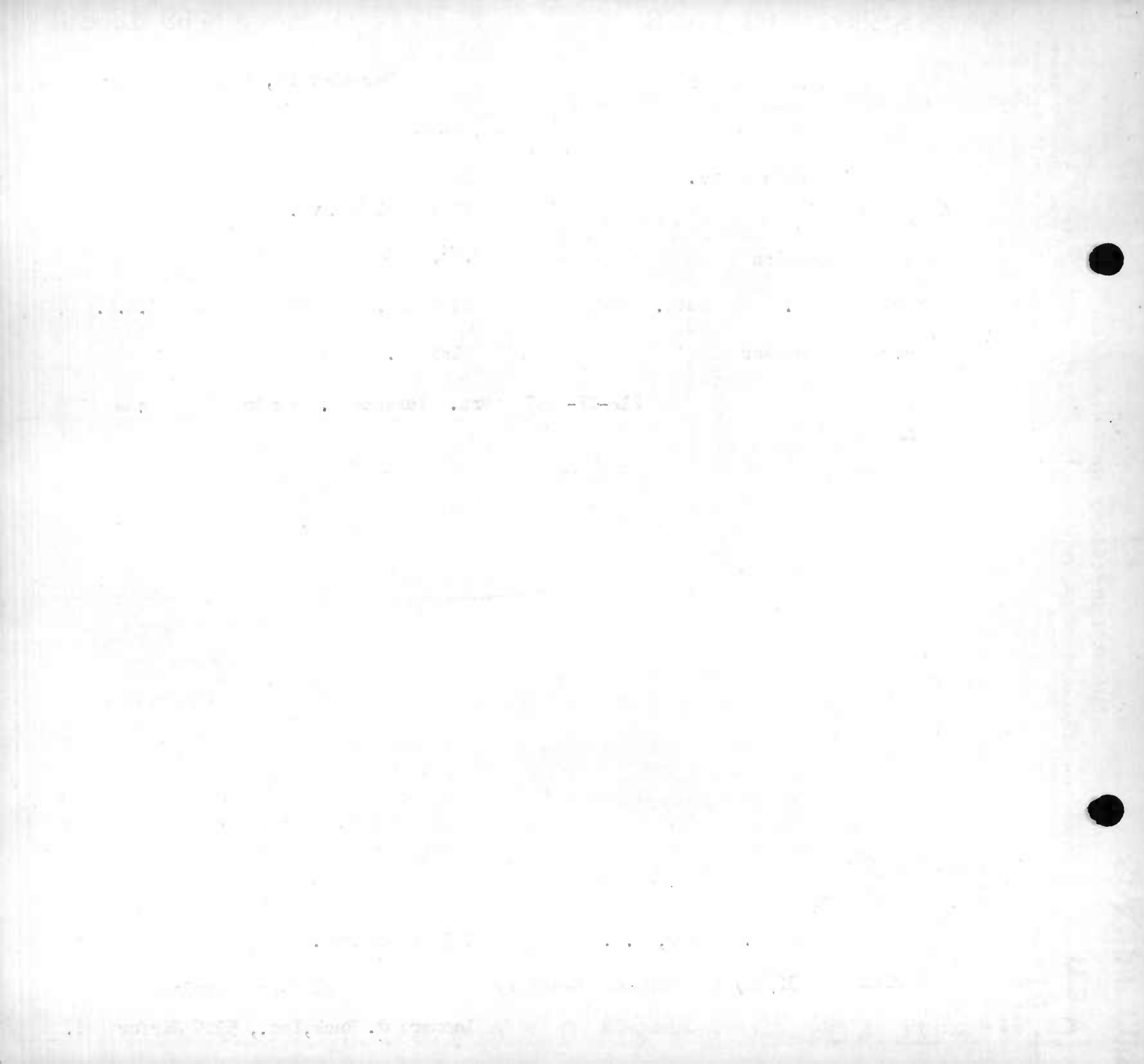




# FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="float: right;">69 12686</span>	
<div style="display: flex; justify-content: space-between;"> <span>5-560 69 12686</span> <span><b>CERTIFICATE OF DEATH</b></span> </div>					
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		John Sommer		December 21, 1969 8:00 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			A. STATE B. COUNTY		
7717 Daniels Ave.			Maryland		
00			C. CITY OR TOWN		D. INSIDE CITY LIMITS?
			Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER		
			7717 Daniels Ave.		
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years lost birthday)	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
Male	Caucasian	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	1/29/1904	65	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Foreman Ret.		Beth. Steel		Baltimore, Maryland	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
Charles Sommer			Elsie B. Leese		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT	
No		212-07-5557		Mrs. Florence H. Sommer	
				ADDRESS	
				Same	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			CAUSE OF DEATH		
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)			ACUTE MYOCARDIAL INFARCTION		
ANTECEDENT CAUSES			(A) IMMEDIATE CAUSE		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			DUE TO, OR AS A CONSEQUENCE OF:		
			ARTERIO SCLEROTIC CARDIO-VASCULAR DISEASE		
			(B) DUE TO, OR AS A CONSEQUENCE OF:		
			(C) DUE TO, OR AS A CONSEQUENCE OF:		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 19 to 19, that (I) (we) last saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Larry G. Tilley				12-22-69	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
Larry G. Tilley, M.D.				1713 Taylor Ave.	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		12/24/69		Parkwood Cemetery	
				24D. LOCATION (City, town, or county) (State)	
				Baltimore Maryland	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
DEC 24 1969		Robert E. Taylor, M.D.		Leonard J. Ruck, Inc., 5305 Harford Rd.	

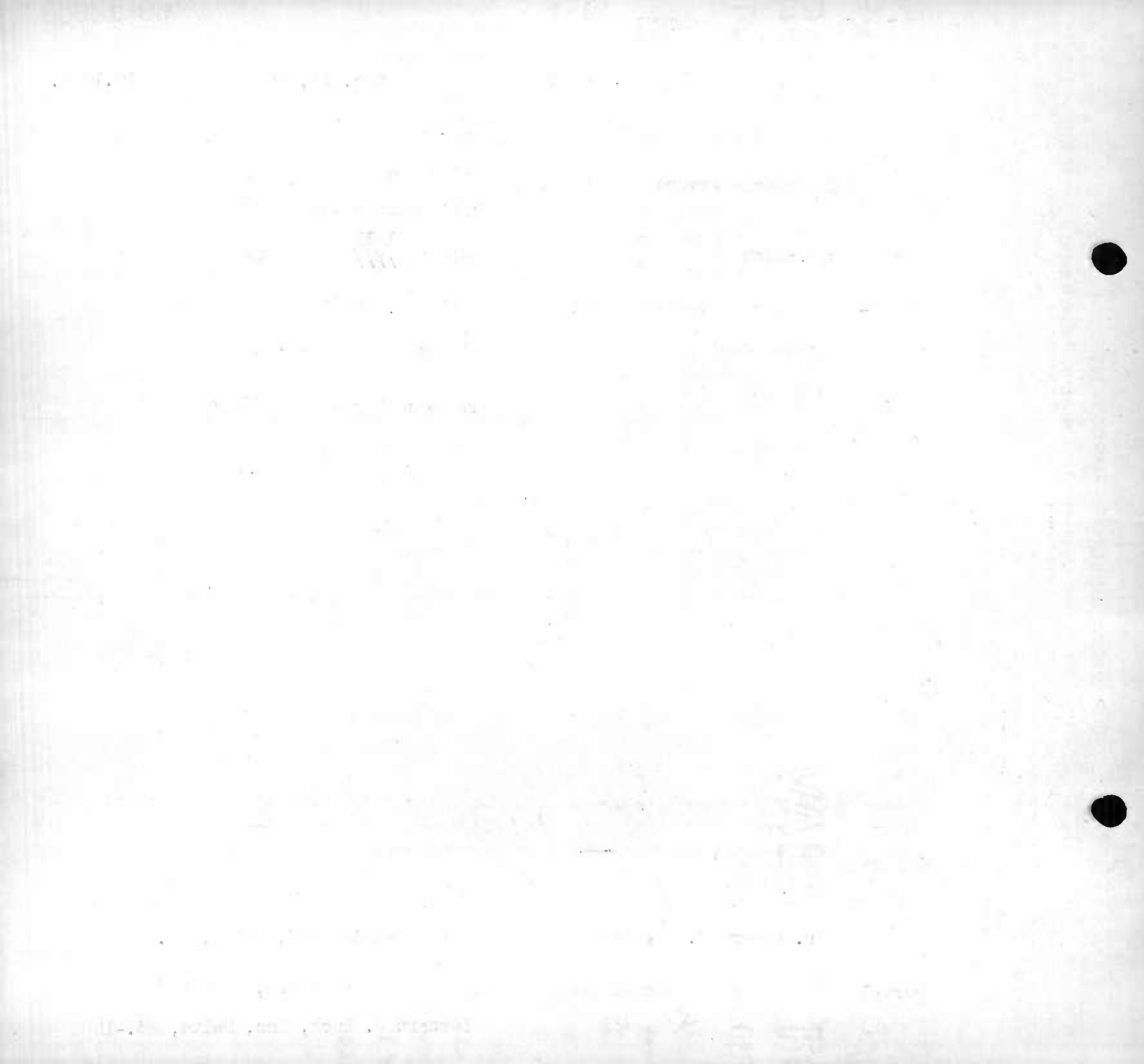


BIRTH NO.		1. NAME OF DECEASED (Type or Print) Robert Truelove		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 2801 Season St.		3. DATE PRONOUNCED DEAD Month Day Year Hour 12 21 69 11:50P.M.		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 1201	
6. SEX Male	7. RACE White	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		C. CITY OR TOWN Balto.	
9. DATE OF BIRTH May 2, 1918		10. AGE (In years last birthday) 51	11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME John A Truelove		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Watchman		15. MOTHER'S MAIDEN NAME Marie A Shanahan	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes WW 11		17. SOCIAL SECURITY NO.		18. INFORMANT Mrs Mary Marcella	
19. CAUSE OF DEATH 4124 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic Cardiovascular Disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. Neck & Craniocerebral injuries Cirrhosis of the liver		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		21. AUTOPSY? (Yes or No) yes	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) yes	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE: Russell S. Fisher, M.D. DATE SIGNED: 12-22-69 EXAMINER'S NAME (Type)					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/24/69		24C. NAME OF CEMETERY or CREMATORY Baltimore National	
24D. LOCATION (City, town, or county) (State) Baltimore, Maryland		25A. DATE REC'D BY HEALTH DEPT. DEC 24 1969		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.	
25C. FUNERAL DIRECTOR Leonard J Ruck Inc. Baltimore, Maryland		25D. ADDRESS			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

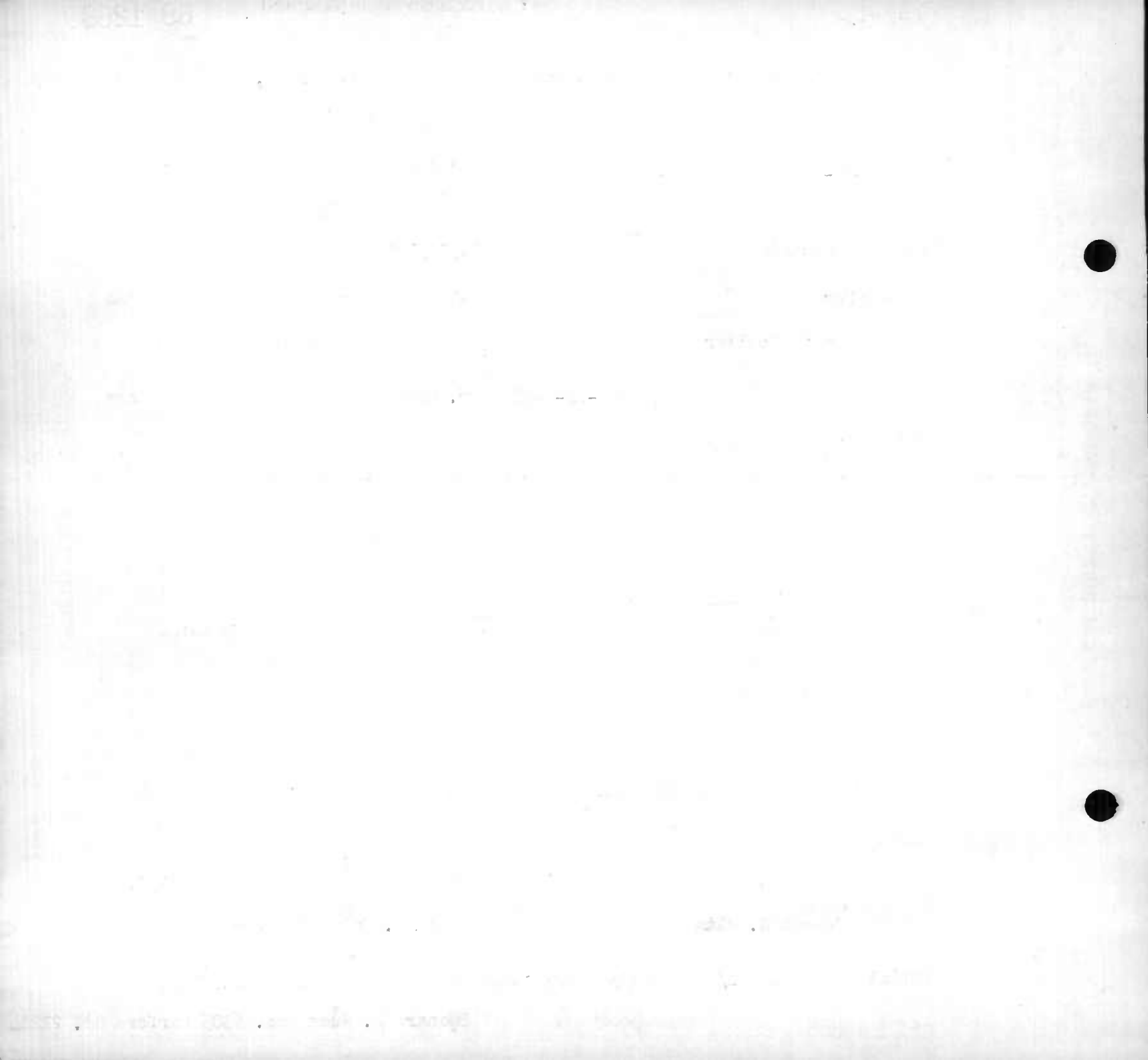
<div style="display: flex; justify-content: space-between;"> <span>C-500</span> <span>69 12688</span> <span>BALTIMORE CITY HEALTH DEPARTMENT</span> </div> <div style="display: flex; justify-content: space-between;"> <span></span> <span>CERTIFICATE OF DEATH</span> <span>REG. NO. 69 12688</span> </div>			
BIRTH NO. 1. NAME OF DECEASED (Type or Print) JOSEPH FRANKLIN COMI		2. DATE AND HOUR OF DEATH Dec. 21, 1969 10.10 p. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 3921 Lyndale Avenue		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 26 43 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 3921 Lyndale Avenue	
5. SEX male	6. RACE caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1911 April 8, 1969
		9. AGE (In years last birthday) 58	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Operator-proprietor		10B. KIND OF BUSINESS OR INDUSTRY vending machines	
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Louis Comi		14. MOTHER'S MAIDEN NAME Concetta Grande	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO.	17. INFORMANT Mrs Rita H Comi ADDRESS Same
18. 197.8 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Hepatic Coma (B) Carcinoma of the liver DUE TO, OR AS A CONSEQUENCE OF: (C) Abscess Omentum Carcinoma	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH — > 3 mos.	
19A. DATE OF OPERATION 0	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 12/15/69 to 12/21/69, that (I) (we) last saw the deceased alive on 12/15/69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Dr. Albert B. Bradley		23B. DATE SIGNED 12/22/69	23C. PHYSICIAN'S NAME (Type) Dr. Albert B. Bradley
23D. ADDRESS 4900 Belair Road, Balto, Md.		24A. BURIAL CREMATION, REMOVAL (Specify) burial	
24B. DATE 12/26/69		24C. NAME OF CEMETERY or CREMATORY Sacred Heart Of Mary	
24D. LOCATION (City, town, or county) (State) Baltimore, Maryland		25A. DATE REC'D BY HEALTH DEPT. DEC 24 1969	
25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Leonard J. Ruck, Inc, Balto, Md.-14	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

S-636		69 12689		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 69 12689	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) <b>Florence Elizabeth Schroeter</b>			
2. DATE AND HOUR OF DEATH <b>December 20, 1969</b>				M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>Mid-Town Nursing Home</b> <b>90</b>				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>2748</b>			
5. SEX <b>Female</b>				6. RACE <b>Caucasian</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <b>11/13/1905</b>		9. AGE (In years last birthday) <b>64</b>		If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Homemaker</b>				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Baltimore Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>				13. FATHER'S NAME <b>Edgar Coulter</b>			
14. MOTHER'S MAIDEN NAME <b>Mary Arbin</b>				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>			
16. SOCIAL SECURITY NO. <b>217-22-7995</b>				17. INFORMANT <b>Mr. Frederick Schroeter</b>			
ADDRESS <b>Same</b>							
18. <b>412.2 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>C.V.A.</b> (B) DUE TO, OR AS A CONSEQUENCE OF: <b>Hypertensive Cardio-Vascular Disease</b> (C) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>10/15/69</b> <b>?</b>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 19A. DATE OF OPERATION <b>0</b>				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			
20A. AUTOPSY? (Yes or No) <b>No</b>				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)			
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>10/15/69</b> to <b>12/20/69</b> 19____, that (I) (we) last saw the deceased alive on <b>12/20</b> 19____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Joseph S. Blum</b> DEGREE <b>M.D.</b>				23B. DATE SIGNED <b>12/22/69</b>			
23C. PHYSICIAN'S NAME (Type) <b>Joseph S. Blum</b>				23D. ADDRESS <b>1115 N. Calvert Street</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12/24/69</b>		24C. NAME of CEMETERY or CREMATORY <b>Loudbn Park Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 24 1969</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor, M.D.</b>		25C. FUNERAL DIRECTOR <b>Leonard J. Rick Inc.</b>		ADDRESS <b>5305 Harford Rd. 21214</b>	





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

S-140		69 12690		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 69 12690	
<b>CERTIFICATE OF DEATH</b>							
1. NAME OF DECEASED (Type or Print) <u>Guillemette Schubel</u> <i>(Wilhelmina)</i>				2. DATE AND HOUR OF DEATH <u>12/20/69</u> <u>17:25 A</u> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>1201</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>USPHS HOSPITAL, BALTO, MD.</u>				C. CITY OR TOWN <u>Balto.</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				E. STREET AND NUMBER <u>3810 JUNIPER Rd.</u>			
5. SEX <u>F</u>	6. RACE <u>CAUCASIAN</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1-23-1890</u>	9. AGE (In years last birthday) <u>79</u>	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOME MAKER</u>				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>GERMANY</u>	
13. FATHER'S NAME <u>(HENRY) SCHMITZ</u> <i>Heinrich</i>				14. MOTHER'S MAIDEN NAME <u>(CAROLINE) KASPAR</u> <i>KATHERINE</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) <u>NO</u> Ill yes, give war or dates of service				16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>CHART MRS Edith S. Zedley - SAME</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>191X I</u> <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>METASTATIC MALIGNANT MELANOMA OF THE BRAIN</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>WEEKS</u>	
19A. DATE OF OPERATION <u>12-11-69</u>				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>BRAIN TUMOR</u>		20A. AUTOPSY? (Yes or No) <u>YES</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>YES</u>	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <u>we</u> (this hospital) attended the deceased from <u>12/7</u> 19 <u>69</u> to <u>12/20</u> 19 <u>69</u> that <u>we</u> lost saw the deceased alive on <u>12/20</u> 19 <u>69</u> and that in <u>my</u> (our) opinion death occurred on the date and hour and from the causes stated above. <u>we</u> (We) (did) <u>did not</u> view the body after death.							
23A. SIGNATURE <u>Gary E. Feldman, M.D.</u>				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <u>12/21/69</u>	
23C. PHYSICIAN'S NAME (Type) <u>GARY E. FELDMAN, M.D.</u>				23D. ADDRESS <u>USPHS HOSP. BALTO.</u>			
24A. BURIAL - CREMATION, REMOVAL (Specify)		24B. DATE <u>12/23/69</u>		24C. NAME of CEMETERY or CREMATORY <u>Greenmount Crem.</u>		24D. LOCATION (City, town, or county) (State) <u>BALTIMORE, MD.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>DEC 24 1969</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>		25C. FUNERAL DIRECTOR <u>BUCK, INC.</u>		ADDRESS <u>BALTIMORE, MD.</u>	



# FUNERAL DIRECTOR: IMPORTANT

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<h2 style="margin: 0;">I-524 69 12691</h2>		<h2 style="margin: 0;">BALTIMORE CITY HEALTH DEPARTMENT</h2>		<h2 style="margin: 0;">CERTIFICATE OF DEATH</h2>		<h2 style="margin: 0;">REG. NO. 69 12691</h2>	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
		FLORENCE I. INGBLS		Dec. 20, 1969		4:15 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE		B. COUNTY	
				MARYLAND		BALTIMORE CO.	
CAURCH HOME & HOSPITAL				C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
				BALTIMORE		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
35				E. STREET AND NUMBER			
				4708 MARYKNOLL RD.			
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)	
♀	W			7-27-94		75	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Homemaker				BALTIMORE, MARYLAND		USA	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<del>XXXXXXXXXXXX</del> Thomas Perragoy				<del>XXXXXXXXXXXX</del> Madeleine Stevenson			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT			
		214-18-9312		Mr. William Ingles <del>XXXXXXXXXXXX</del> 648 Riverside Drive			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES  DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH			
				(A) IMMEDIATE CAUSE Cerebral Embolism DUE TO, OR AS A CONSEQUENCE OF:			
				(B) DUE TO, OR AS A CONSEQUENCE OF:			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				ARTERIOSCLEROTIC HEART DISEASE			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from Dec. 19 19 69 to Dec. 20 19 69 that (I) (we) last saw the deceased alive on Dec. 20 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
Corazon Z. Vergara, M.D.				Dec. 20, 1969			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
CORAZON Z. VERGARA, M.D.				Church Home & Hosp., Baltimore, Md. 21203			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		12/24/69		Reisterstown Methodist Church		Reisterstown Maryland	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
DEC 24 1969		Robert E. Taylor, M.D.		J. P. Ruck		5305 Harford Road 21214	



Body Released By Dr. Minhalakis (per Magrison)  
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

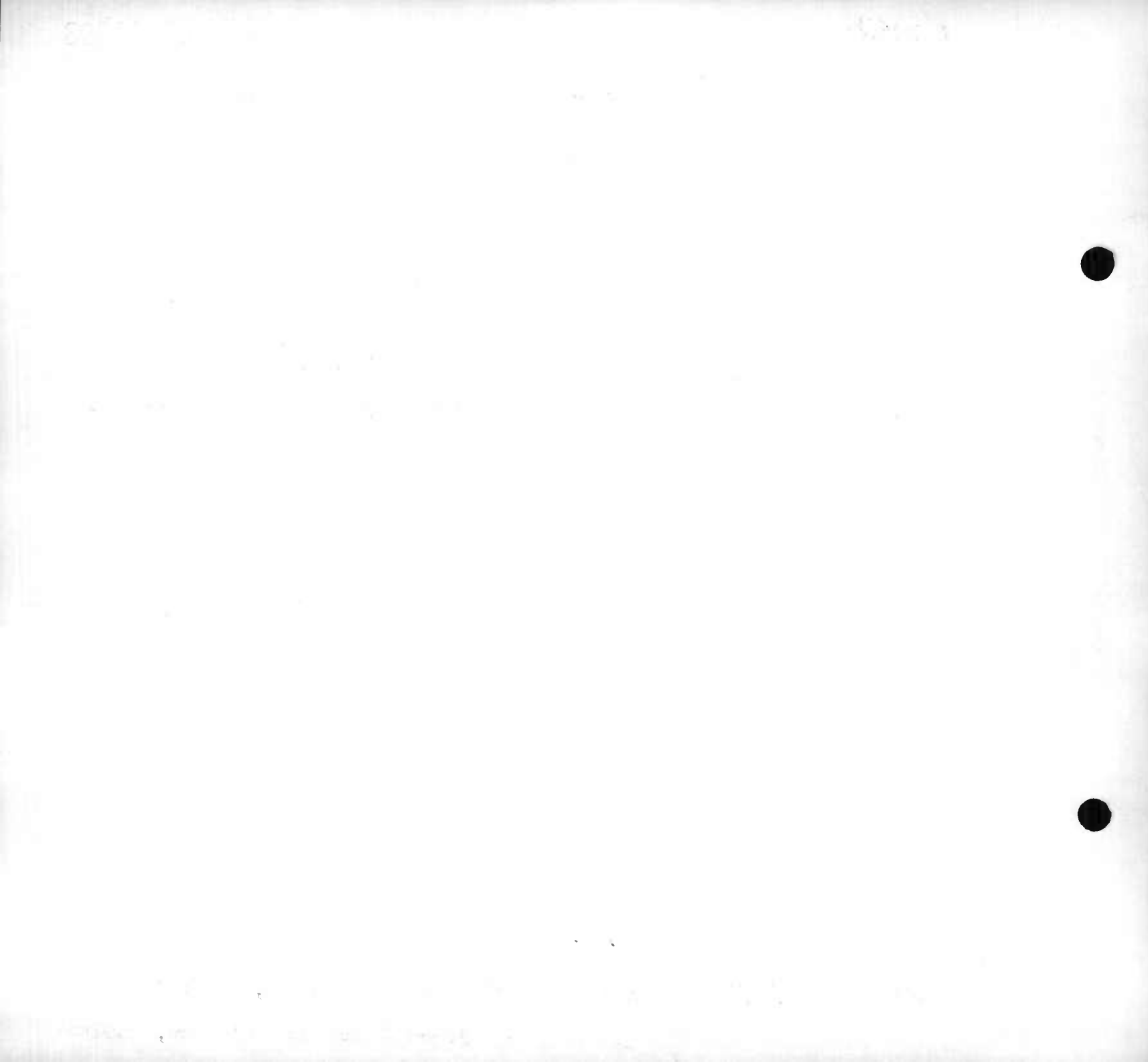
H-632 69 12692				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 69 12692	
BIRTH NO.				2. DATE AND HOUR OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>LYLE W. HARD GROVE</u>				12/19/69 7:00 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>MERCY HOSPITAL</u> <u>37</u>				A. STATE <u>MD</u>		B. COUNTY <u>1102</u>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				C. CITY OR TOWN <u>BALTIMORE</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <u>M</u>				6. RACE <u>CAUCASIAN</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	
8. DATE OF BIRTH <u>4/24/10</u>				9. AGE (In years lost birthday) <u>59</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>GUARD</u>	
11. BIRTHPLACE (State or foreign country) <u>VIRGINIA</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>LYLE HARD GROVE</u>	
14. MOTHER'S MAIDEN NAME <u>BARTH MCCORMICK</u>				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>213-05-6572</u>	
17. INFORMANT <u>WIFE</u>				ADDRESS <u>SAME</u>		18. CAUSE OF DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>C.V.A. (CEREBRAL VASCULAR ACCIDENT)</u>				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>C.V.A. (CEREBRAL VASCULAR ACCIDENT)</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>HYPERTENSION</u>				(B) DUE TO, OR AS A CONSEQUENCE OF: <u>HYPERTENSION</u>		YEARS	
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>PNEUMONIA</u>							
19A. DATE OF OPERATION <u>12/13/69</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>C.V.A.</u>		20A. AUTOPSY? (Yes or No) <u>NO</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <u>NEITHER</u>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Approx.) <u>?</u>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <u>?</u>			
22. I certify that (1) (this hospital) attended the deceased from <u>12/12/69</u> to <u>12/19/69</u> and that (2) (we) last saw the deceased alive on <u>12/19/69</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Robert J. Rosensteel M.D.</u>				23B. DATE SIGNED <u>12/19/69</u>		23C. PHYSICIAN'S NAME (Type) <u>ROBERT J. ROSENSTEEL</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>				24B. DATE <u>12/23/69</u>		24C. NAME of CEMETERY or CREMATORY <u>Baltimore National Cemetery</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>DEC 24 1969</u>				25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>		25C. FUNERAL DIRECTOR <u>Leonard J. Ruck Inc.</u>	
25D. LOCATION <u>Baltimore Maryland</u>				25E. ADDRESS <u>5305 Harford Rd. 21214</u>			



# FUNERAL DIRECTOR: IMPORTANT

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<div style="display: flex; justify-content: space-between;"> <span>P-140</span> <span>69 12693</span> <span>BALTIMORE CITY HEALTH DEPARTMENT</span> <span>X REG. NO. 69 12693</span> </div>					
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>BERNARD T. POFFEL</b>		2. DATE AND HOUR OF DEATH <b>12/22/69 5:00 P.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <b>CHURCH HOME + HOSPITAL</b> <b>35</b>			A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTIMORE</b>		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			C. CITY OR TOWN <b>BALTIMORE</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER <b>1809 WENTWORTH RD</b>		
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5/29/10</b>	9. AGE (In years last birthday) <b>59</b>	10. Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SALESMAN</b>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			13. FATHER'S NAME <b>MICHAEL POFFEL</b>		
14. MOTHER'S MAIDEN NAME <b>Marion Rutkowski</b>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		
16. SOCIAL SECURITY NO. <b>218147159</b>			17. INFORMANT <b>Mrs Ethel M Poffel</b> Same		
18. CAUSE OF DEATH					
<div style="display: flex; justify-content: space-between;"> <div> <p><b>162.1 I</b></p> <p><b>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b></p> <p>(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)</p> <p><b>ANTECEDENT CAUSES</b></p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p> </div> <div> <p><b>CA OF LUNG</b></p> <p><b>WITH GENERAL METASTASIS?</b></p> </div> <div> <p>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>symptoms - 3 wks</b></p> </div> </div>					
<p><b>II</b></p> <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</p>					
19A. DATE OF OPERATION <b>11/25/69</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>CA OF LUNG</b>		20A. AUTOPSY? (Yes or No) <b>yes</b>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>11/15/69</b> 19 to <b>12/22/69</b> 19					
that (I) (we) last saw the deceased alive on <b>12/22/69</b> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Ricardo M. Tuason MD</b>				23B. DATE SIGNED <b>12/22/69</b>	
23C. PHYSICIAN'S NAME (Type) <b>Ricardo M. Tuason MD</b>				23D. ADDRESS <b>100 N. Broadway BALTIMORE</b>	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <b>12/26/69</b>		24C. NAME of CEMETERY or CREMATORY <b>Moreland Memorial Park</b>	
24D. LOCATION <b>Baltimore, Maryland</b>		24E. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 24 1969</b>		25B. NAME OF REGISTRAR <b>Robert E. [Signature]</b>		25C. FUNERAL DIRECTOR <b>Leonard J. Ruck Inc</b>	
25D. ADDRESS <b>Baltimore, Maryland</b>					





# FUNERAL DIRECTOR: IMPORTANT

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11-520		69 12694		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 69 12694	
BIRTH NO.				2. DATE AND HOUR OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>Thomas MEANS</b>				Dec. 20, 1969 12 25 P. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE B. COUNTY <b>369 MARYLAND 1605</b>			
FULL NAME OF HOSPITAL OR INSTITUTION <b>46 LUTHERAN HOSPITAL-730 Ashburton St</b>				C. CITY OR TOWN <b>BAITIMORE</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				E. STREET AND NUMBER <b>2569 Edmondson Ave.</b>			
5. SEX <b>male</b>	6. RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3-30-79</b>	9. AGE (In years last birthday) <b>90</b>	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Cement Finisher</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>		11. BIRTHPLACE (State or foreign country) <b>N.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>Thomas Means Sr.</b>			14. MOTHER'S MAIDEN NAME <b>Katie Lee</b>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>			16. SOCIAL SECURITY NO. <b>217-47-5412A</b>		17. INFORMANT <b>Thomas Means Jr. 2569 Edmondson Ave.</b>		ADDRESS
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.) <b>445.9 I</b>			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Gangrene Rt foot (dec)</b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>7 days</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Hypotension</b>			(B) DUE TO, OR AS A CONSEQUENCE OF: <b>Cardiac arrhythmias</b>				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION <b>3 12/17/68</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Gangrene</b>		20A. AUTOPSY? (Yes or No) <b>Yes</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>-</b>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <b>-</b>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <b>-</b>			
22. I certify that (I) (this hospital) attended the deceased from <b>12/13</b> 19 <b>68</b> to <b>12/20</b> 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>12/20</b> 19 <b>68</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Subash C. Ahuja M.D.</b>				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>12/20/68</b>	
23C. PHYSICIAN'S NAME (Type) <b>SURASH C. AHUJA M.D.</b>				23D. ADDRESS <b>Lutheran Hospital</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12/23/69</b>		24C. NAME OF CEMETERY or CREMATORY <b>Mt Zion Cem.</b>		24D. LOCATION (City, town, or county) (State) <b>Lansdowne Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 24 1969</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR <b>William J. Daniel/Hane</b>		ADDRESS <b>397 Schrodter St</b>	

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

H-220		69 12695		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 69 12695	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) <b>TENNIE E. HUGHES</b>			
2. DATE AND HOUR OF DEATH <b>12/21/69 3:30 P.M.</b>				3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			
FULL NAME OF HOSPITAL OR INSTITUTION <b>31</b>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>BALTIMORE CITY HOSPITALS 4940 Eastern Avenue Baltimore, Maryland 21224</b>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>402</b>		C. CITY OR TOWN <b>Baltimore</b>	
D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		E. STREET AND NUMBER <b>244 N. Pine St. 21201 007</b>		5. SEX <b>Female</b>		6. RACE <b>Negro</b>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>7-8-91</b>		9. AGE (In years last birthday) <b>78</b>		10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Montgomery Co Md.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Vaechel Lyles</b>				14. MOTHER'S MAIDEN NAME <b>Clara Zeigler</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>212-12-5868</b>		17. INFORMANT <b>BCH-Records 4940 Eastern Avenue Baltimore, Maryland 21224</b>			
18. <b>157.0 I</b>		CAUSE OF DEATH <b>CARCINOMA OF HEAD</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 YEAR</b>			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE OF PANCIEAS DUE TO, OR AS A CONSEQUENCE OF:					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF:					
(C) DUE TO, OR AS A CONSEQUENCE OF:							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION <b>08/20/69</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>OBSTRUCTIVE JAUNDICE</b>		20A. AUTOPSY? (Yes or No) <b>NO</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (H) (this hospital) attended the deceased from <b>OCT 9 19 69</b> to <b>DEC. 21 19 69</b> that (H) (we) last saw the deceased alive on <b>DEC. 21 19 69</b> and that (in my) (last) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Dennis W. Bleakley MD</b>				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>12/21/69</b>	
23C. PHYSICIAN'S NAME (Type) <b>Dennis W. Bleakley MD.</b>		23D. ADDRESS <b>BCH- 4940 Eastern Avenue Baltimore, Maryland 21224</b>					
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12/24/69</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Pleasant Grove C.C. Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Purdom Md</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 24 1969</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor, M.D.</b>		25C. FUNERAL DIRECTOR <b>William D. ...</b>		ADDRESS <b>3197 ...</b>	



# FUNERAL DIRECTOR: IMPORTANT

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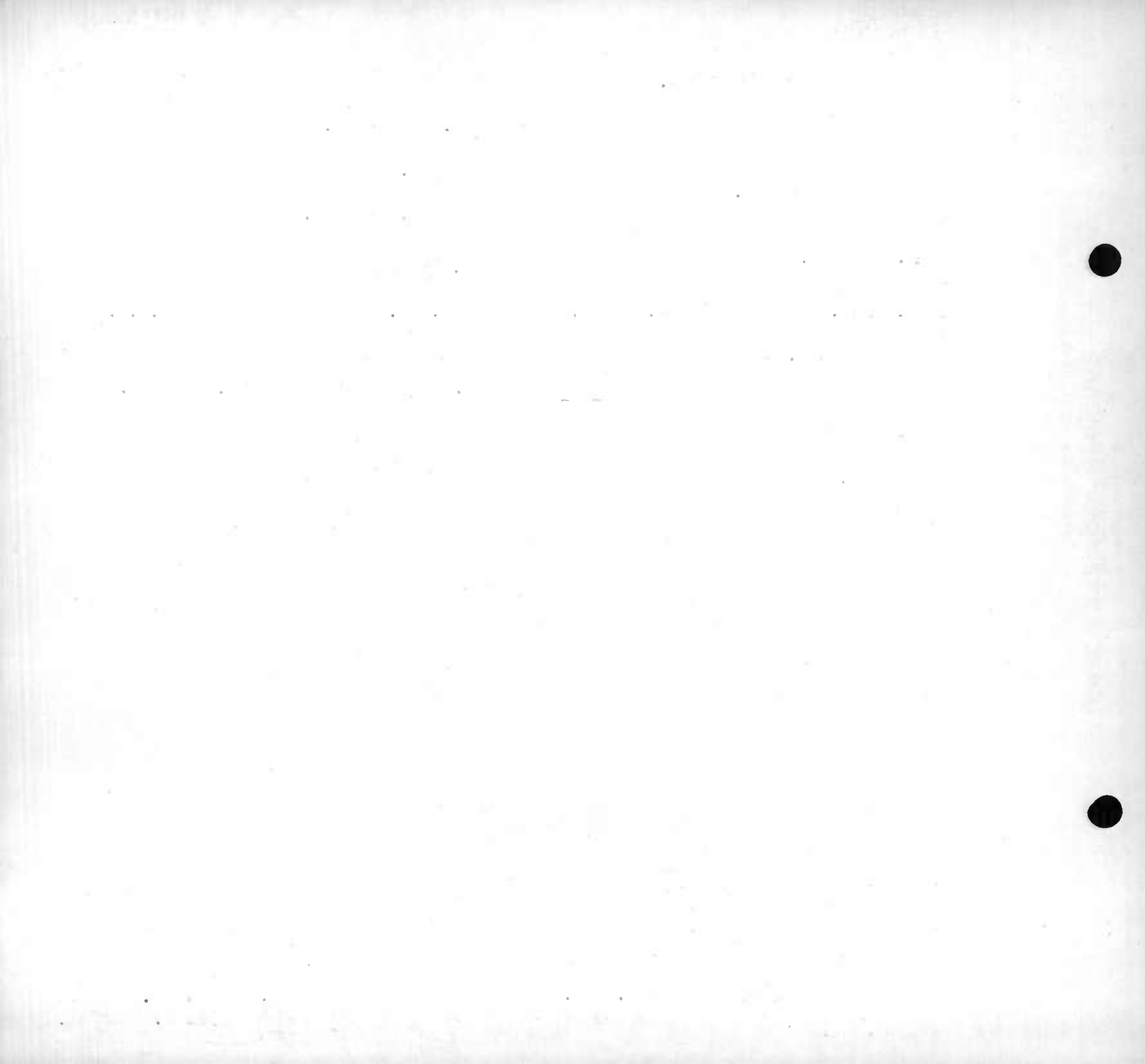
C-150 69 12696		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 69 12696	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		FRANCO CIFONI		12-20-69 5:00 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institutions residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 37 MERCY HOSPITAL		A. STATE MARYLAND		B. COUNTY 302	
IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION		C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER 409 S. HIGH ST.			
5. SEX MALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-21-83	9. AGE (In years last birthday) 86	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		10B. KIND OF BUSINESS OR INDUSTRY CONS.		11. BIRTHPLACE (State or foreign country) ITALY	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME NICOLI CIFONI		14. MOTHER'S MAIDEN NAME <del>FRANCO CIFONI</del>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. JI 217-56-7979		17. INFORMANT 409 S. HIGH ST. MRS. THERESA BRUNO	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) 436.9 I CAUSE OF DEATH CVA, embolus or thrombus		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
		(B) DUE TO, OR AS A CONSEQUENCE OF:			
		(C) DUE TO, OR AS A CONSEQUENCE OF:			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Acute MI					
19A. DATE OF OPERATION 2	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) YES	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?			
22. I certify that (X) (this hospital) attended the deceased from 12-18-1969 to 12-20-1969 that (X) (we) last saw the deceased alive on 12-20-1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. (partial autopsy)					
23A. SIGNATURE Bayani L. Manalo, M.D.		23B. DATE SIGNED 12-21-69		23C. PHYSICIAN'S NAME (Type) BAYANI L. MANALO, M.D.	
23D. ADDRESS 609 S. HIGH ST. BALTIMORE		23E. ADDRESS 322 S. HIGH ST.			
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE 12/24/69	24C. NAME OF CEMETERY or CREMATORY HOLY REDEEMER	24D. LOCATION (City, town, or county)	24E. LOCATION (City, town, or county)	
BURIAL	12/24/69	HOLY REDEEMER	BELAIR RD.	BALTO. Md.	
25A. DATE REC'D BY HEALTH DEPT. DEC 24 1969	25B. NAME OF REGISTRAR Robert E. Fisher, M.D.	25C. FUNERAL DIRECTOR Frank J. Wilkerson	25D. ADDRESS 322 S. HIGH ST.		



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

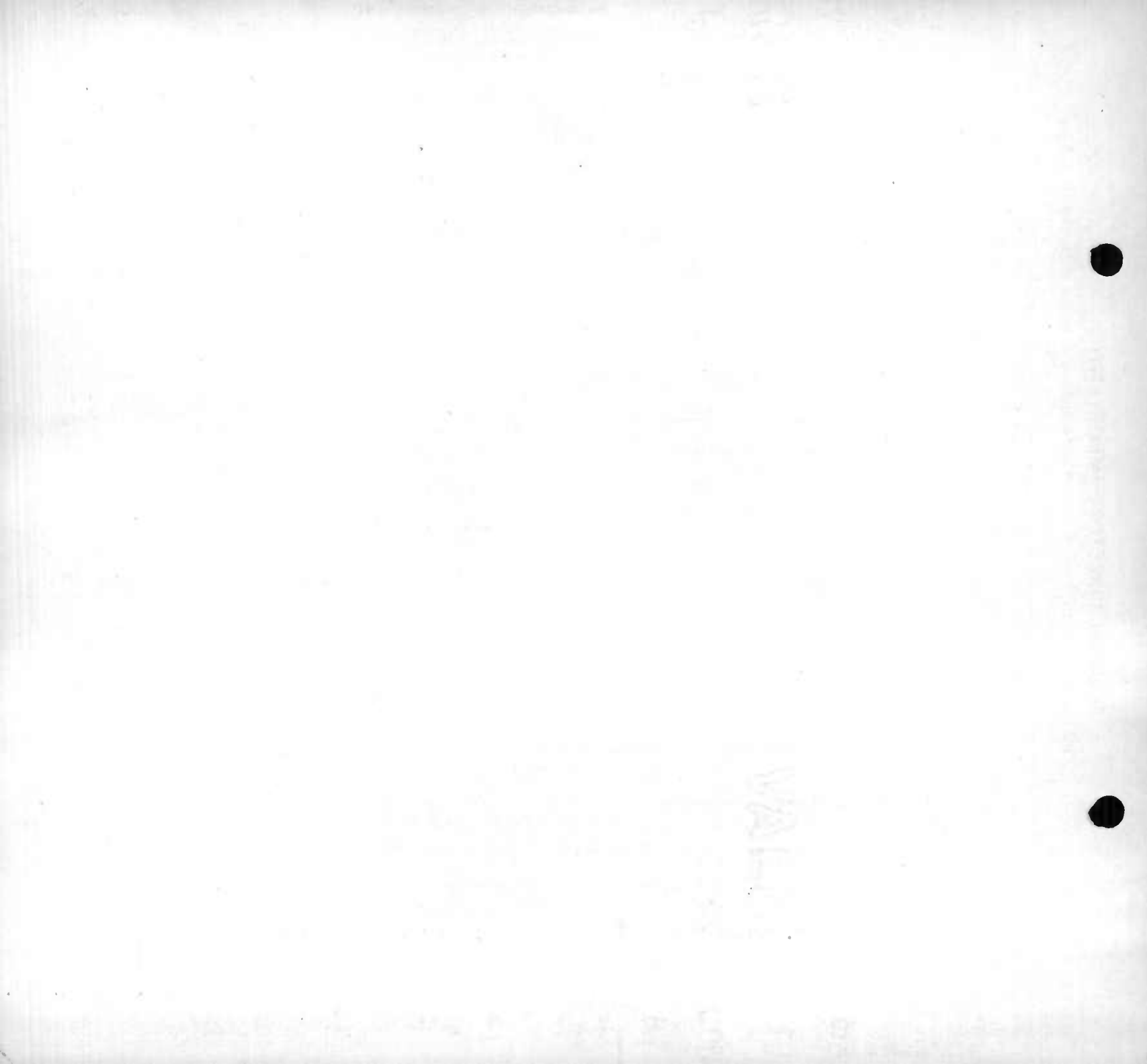
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="float: right;">69 12697</span>	
<b>BIRTH NO.</b> <b>1. NAME OF DECEASED</b> (Type or Print) <span style="float: right;">JOSEPH V. RATTINI</span>		<b>2. DATE AND HOUR OF DEATH</b> <div style="display: flex; justify-content: space-between;"> <span>12/20/69</span> <span>11:00 PM M.</span> </div>			
<b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b>  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  35 CHURCH HOME HOS.		<b>4. USUAL RESIDENCE</b> (Where deceased lived. If institution: residence before admission) <div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <b>A. STATE</b> Md.                             </div> <div style="width: 45%;"> <b>B. COUNTY</b> BALTO.                             </div> </div> <b>C. CITY OR TOWN</b> BALTO. <b>D. INSIDE CITY LIMITS?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
<b>5. SEX</b> M.		<b>6. RACE</b> W.		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
<b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) BLDG. INSP.		<b>10B. KIND OF BUSINESS OR INDUSTRY</b> BALTO. CITY.		<b>8. DATE OF BIRTH</b> AUG. 1st /13	
<b>13. FATHER'S NAME</b> LOUIS A. RATTINI		<b>14. MOTHER'S MAIDEN NAME</b> MARY VARELLA		<b>9. AGE</b> (In years last birthday) 56 If Under 1 Yr. Months: Days: Hours: Min.	
<b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service) NO		<b>16. SOCIAL SECURITY NO.</b> 216-03-1194		<b>17. INFORMANT</b> MRS. STELLA RATTINI 304 S. HIGH ST. ADDRESS	
<b>18. I</b> <b>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)  <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		<b>CAUSE OF DEATH</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>myocardial infarction</i> (B) <i>arteriosclerotic heart disease</i> (C) <i>hypertension</i>		<b>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</b> <i>recent</i> <i>10 yrs</i> <i>10 yrs</i>	
<b>II</b> <b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).</b>					
<b>19A. DATE OF OPERATION</b> 19 <u>0</u>		<b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b>		<b>20A. AUTOPSY?</b> (Yes or No) <i>NO</i>	
<b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (nately medical examiner) <input type="checkbox"/>		<b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		<b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)	
<b>21D. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (APPROX.)		<b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Nat While At Work <input type="checkbox"/>		<b>21F. HOW DID INJURY OCCUR?</b>	
<b>22. I certify that (I) (this hospital) attended the deceased from 19 <u>66</u> to <u>12/20/69</u> 19 <u>69</u>, that (I) <u>we</u> last saw the deceased alive on <u>12/18/69</u> 19 <u>69</u> and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</b>					
<b>23A. SIGNATURE</b> <i>Joseph D'Antonio</i>				<b>23B. DATE SIGNED</b> <u>12/23/69</u>	
<b>23C. PHYSICIAN'S NAME</b> (Type) <i>Joseph D'Antonio</i>				<b>23D. ADDRESS</b> <i>100 N Broadway Balto. Md.</i>	
<b>24A. BURIAL CREMATION, REMOVAL</b> (Specify) BURIAL		<b>24B. DATE</b> <u>12/24/69</u>		<b>24C. NAME OF CEMETERY or CREMATORY</b> BALTO. CEM.	
<b>24D. LOCATION</b> (City, town, or county) (State) NORTH AND ROSE STS. BALTO. Md.		<b>25A. DATE REC'D BY HEALTH DEPT.</b> DEC 24 1969			
<b>25B. NAME OF REGISTRAR</b> <i>Robert F. ...</i>		<b>25C. FUNERAL DIRECTOR</b> <i>Frank ...</i>			
<b>ADDRESS</b> 322 S. HIGH ST.					





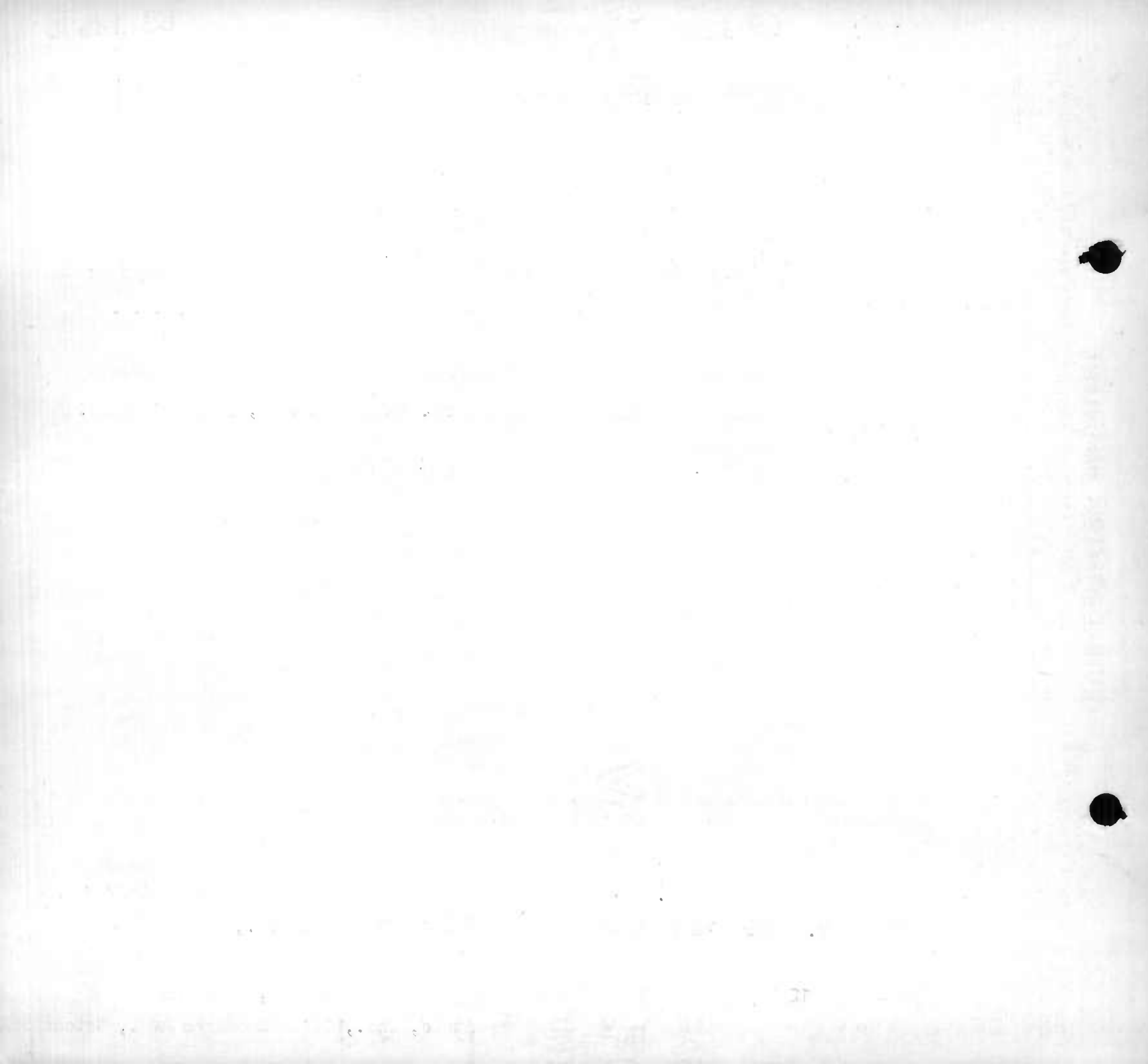
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

VS 150-REV. 1/1/68



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

N-425 69 12699				BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 69 12699	
1. NAME OF DECEASED (Type or Print) <b>Anthony Nelligan</b>				2. DATE AND HOUR OF DEATH <b>12-22-69 5:00 P. M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>2854</b>			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>5009 BRIARCLIFT RD. BALTIMORE, MD. 21229</b>				C. CITY OR TOWN <b>BALTIMORE</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <b>5009 BRIARCLIFT RD.</b>							
5. SEX <b>MALE</b>	6. RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>6-14-11</b>	9. AGE (In years last birthday) <b>58</b>	10. Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>				10B. KIND OF BUSINESS OR INDUSTRY <b>Balto City Police</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				13. FATHER'S NAME			
14. MOTHER'S MAIDEN NAME				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO.				17. INFORMANT <b>Mrs. Edith Nelligan, 5009 Briarclift Road</b>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <b>151.9 I</b> <b>CAUSE OF DEATH</b> (A) IMMEDIATE CAUSE <b>Metastatic Carcinoma</b> <b>Carcinoma of Stomach</b> (B) DUE TO, OR AS A CONSEQUENCE OF: (C).....				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>7-28-1969</b> to <b>12-22-1969</b> , that (I) ( <del>we</del> ) last saw the deceased alive on <b>12-22-1969</b> and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>we</del> ) ( <del>did not</del> ) view the body after death.							
23A. SIGNATURE <b>Harry L. Knipp, M.D.</b>				23B. DATE SIGNED <b>12-23-69</b>		23C. PHYSICIAN'S NAME (Type) <b>Dr. Harry Knipp</b>	
23D. ADDRESS <b>4116 Edmondson Ave., BALTO, MD. 21229</b>				23E. FUNERAL DIRECTOR <b>Wynke, Inc.</b>		23F. ADDRESS <b>1630 Edmondson Ave., Catonsville</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12/26/69</b>		24C. NAME of CEMETERY or CREMATORY <b>New Cathedral Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 24 1969</b>		25B. NAME OF REGISTRAR <b>Robert E. Saylor, M.D.</b>		25C. FUNERAL DIRECTOR <b>Wynke, Inc.</b>		25D. ADDRESS <b>1630 Edmondson Ave., Catonsville</b>	



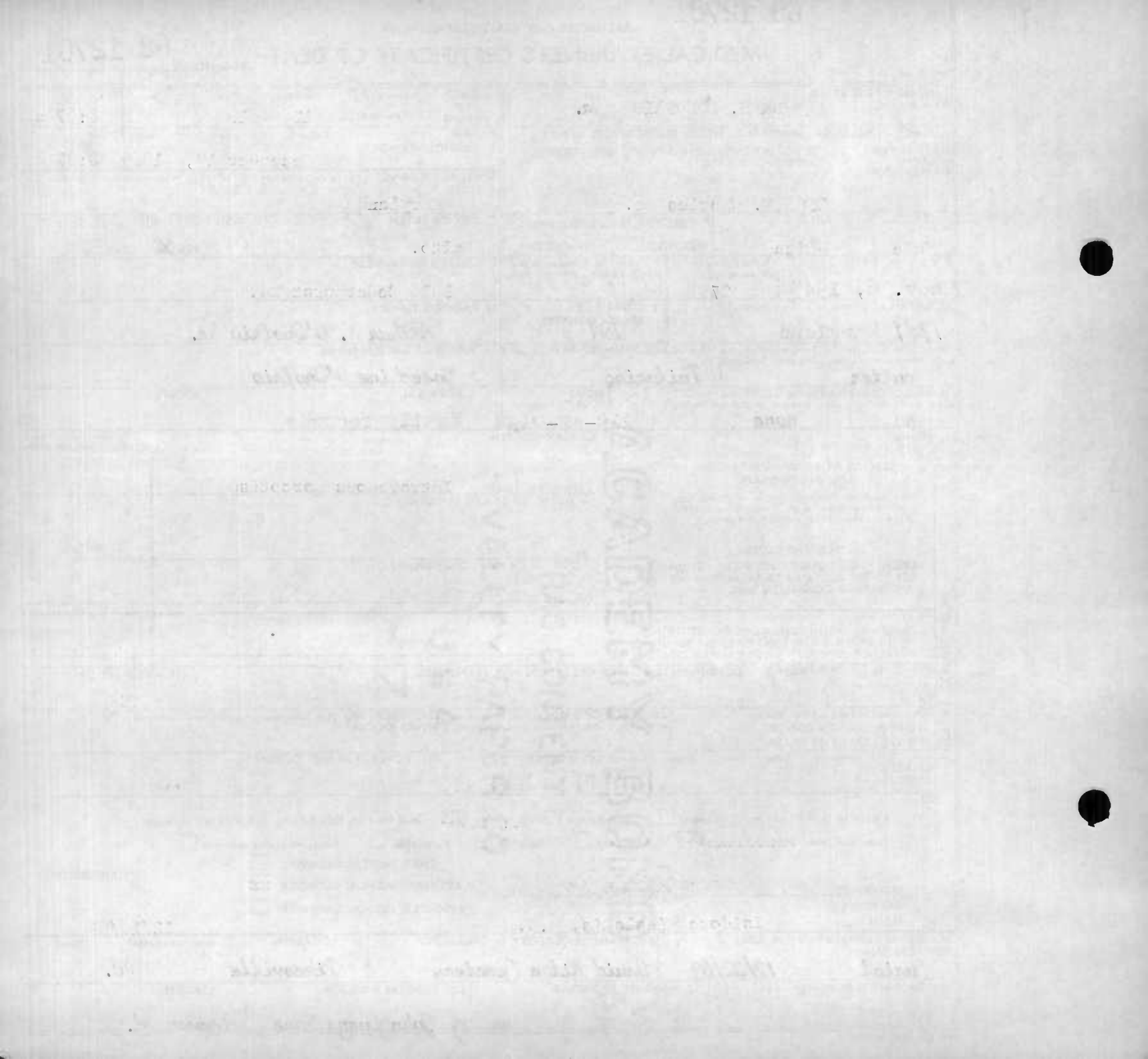
B-300 69 12700 BALTIMORE CITY HEALTH DEPARTMENT X  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH REG. NO. 69 12700

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>Nestor Rayes Bayot</u> <del>HESTER BAYOT</del>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>UNIVERSITY HOSPITAL</u> <u>1-27-70</u>		3. DATE PRONOUNCED DEAD Month Day Year Hour <u>December 20, 1969</u> <u>12:58 A. M.</u>		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>Virginia</u> B. COUNTY <u>V-43</u>	
6. SEX <u>Male</u>	7. RACE <u>Malayan Mongoloid</u>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <u>Norfolk</u>	
9. DATE OF BIRTH <u>Sept. 9, 1939</u>		10. AGE (In years lost birthday) <u>30</u>		E. STREET AND NUMBER <u>USS Muliphen</u>	
11. BIRTHPLACE (State or foreign country) <u>Asmarinas, Amadeo Cavite, Phillipines</u>		12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <u>Benjamin Bayot</u>	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SD-2, U.S. Navy</u>		14B. KIND OF BUSINESS OR INDUSTRY		15. MOTHER'S MAIDEN NAME <u>Teofila R. Bayot</u>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or doles of service) <u>Yes</u>		17. SOCIAL SECURITY NO. <u>551-58-9587</u>		18. INFORMANT <u>U. S. Navy Records</u>	
19. <u>E 965 X</u>		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		Gunshot wounds of the head and chest			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
		(B) DUE TO, OR AS A CONSEQUENCE OF:			
		(C) DUE TO, OR AS A CONSEQUENCE OF:			
ii OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
20A. DATE OF OPERATION <u>2</u>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) <u>yes</u>	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Lounge</u>		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? <u>Howsers Bar and Lounge, 736 Washington Blvd</u>	
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) <u>12-20-69 12:40 A. M.</u>		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? <u>Shot during altercation</u>	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE EXAMINER'S NAME (Type) <u>Isidore Mihalakis, M.D.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>12/20/69</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Removal</u>		24B. DATE <u>Dec. 23, 1969</u>		24C. NAME OF CEMETERY OR CREMATORY <u>DASMARINAS</u>	
24D. LOCATION (City, town, or county) (State) <u>Cavite, Phillipines</u>		25A. DATE REC'D BY HEALTH DEPT. <u>DEC 24 1969</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>	
25C. FUNERAL DIRECTOR <u>Howard County Funeral Home of Harry H. Witke, Ellicott City, Maryland</u>		25D. ADDRESS			

Letter from U.S. Navy  
1-27-70 M.H.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		MEDICAL EXAMINER'S CERTIFICATE OF DEATH		REG. NO.	
1. NAME OF DECEASED (Type or Print)		ARTHUR N. DONOFRIO Jr.		2. DATE OF DEATH		Known <input type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		2508 N. Charles St.		3. DATE PRONOUNCED DEAD		Month Day Year Hour	
6. SEX		7. RACE		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN	
Male		White				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
9. DATE OF BIRTH		10. AGE (In years last birthday)		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Nov. 6, 1943		26		/Bal Maryland		USA	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY		13. FATHER'S NAME		15. MOTHER'S MAIDEN NAME	
cutter		Tailoring		Arthur N. D'Onofrio Sr.		Josephine D'Onofrio	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.		18. INFORMANT		ADDRESS	
no		219-42-0198		Family records			
19. CAUSE OF DEATH		DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		(A) IMMEDIATE CAUSE		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
304.9 I		(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		Intravenous narcotism			
		ANTECEDENT CAUSES		(B) DUE TO, OR AS A CONSEQUENCE OF:			
		DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(C) DUE TO, OR AS A CONSEQUENCE OF:			
		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No)			
2				YES			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME OF INJURY (APPROX.)		22E. INJURY OCCURRED		22F. HOW DID INJURY OCCUR?			
(Month) (Day) (Year) (Hour)		WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>					
23.		I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER		DATE SIGNED	
ACTUAL SIGNATURE		EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>			
		Isidore Mihalakis, M.D.		ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		12/22/69		Druid Ridge Cemetery		Pikesville Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
DEC 24 1969		Robert E. Taylor		John Burns Sons		Tomson Md.	



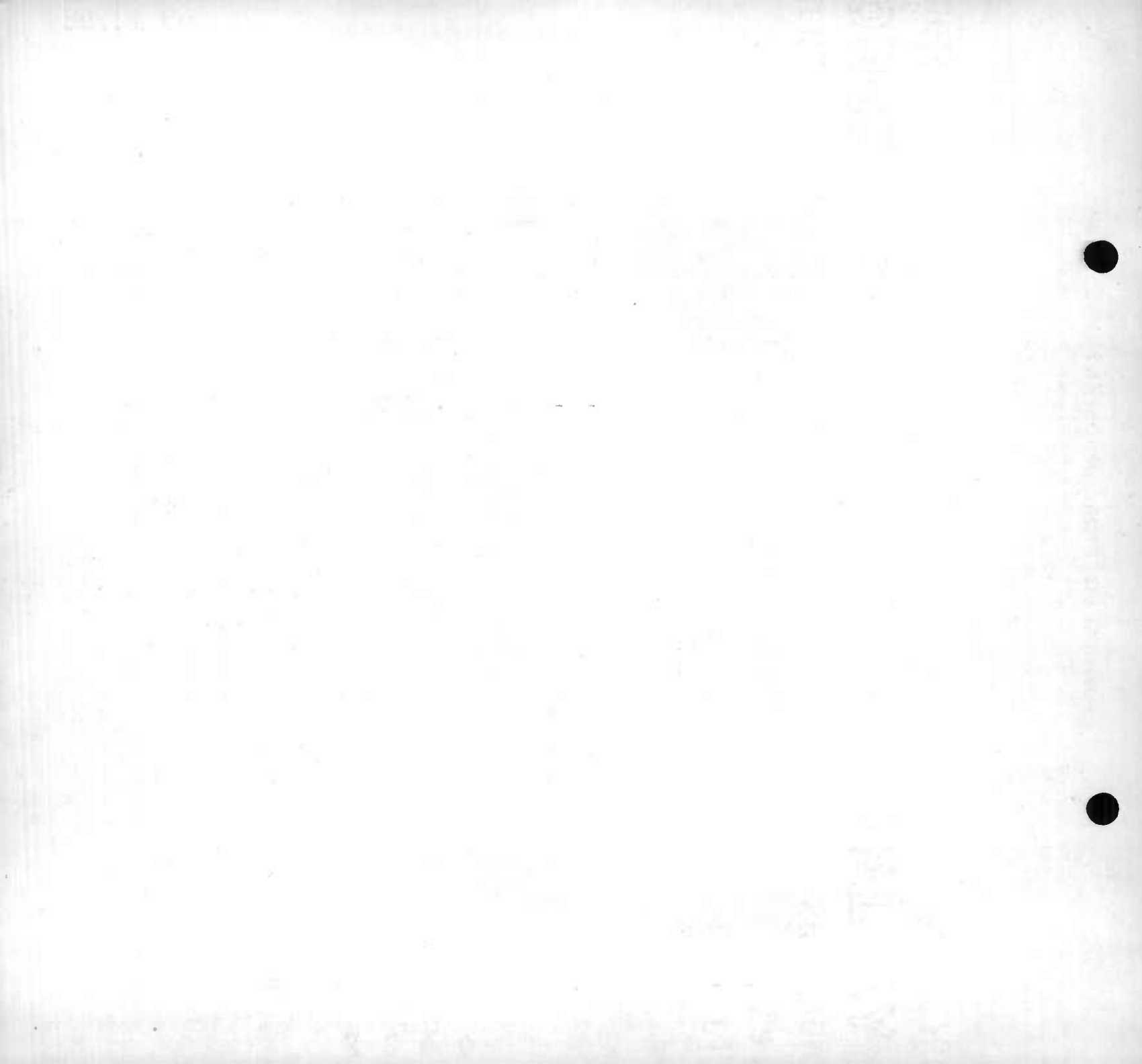




FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				REG. NO. 69 12702	
BIRTH NO. 69 12702		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) IRVIN Frank		2. DATE AND HOUR OF DEATH 12/19/69 1:25 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD Full Name of Hospital or Institution (If not in hospital or institution, give street address or location) Baltimore Hosp. of Maryland 430 Ashburton Bldg. Md.		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE 4015 B. COUNTY Fairfax Rd. MD 1509 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 4015 Fairfax Rd.			
5. SEX M	6. RACE C	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/28/96	9. AGE (In years last birthday) 73	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10B. KIND OF BUSINESS OR INDUSTRY Gas Co. Employee		11. BIRTHPLACE (State or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME William Irvin		14. MOTHER'S MAIDEN NAME Ada Talbvert	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 225-09-0472A		17. INFORMANT ADDRESS Mrs. Viola Irvin 4015 Fairfax Rd.	
18. CAUSE OF DEATH					
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTecedent CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Congestive shock acute coronary occlusion (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) 12 19 69 1:25		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 19 to 19, that (I) (we) last saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Elmo Gayoso		23B. DATE SIGNED 12/19/69		23C. PHYSICIAN'S NAME (Type) ELMO GAYOSO	
24A. BURIAL CREMATION REMOVAL (Specify) Burial		24B. DATE 12-22-69		24C. NAME OF CEMETERY or CREMATORY Mt Auburn Cemetery	
24D. LOCATION Baltimore		24E. STATE Md		24F. CITY, TOWN, OR COUNTY Baltimore	
25A. DATE REC'D BY HEALTH DEPT. DEC 24 1969		25B. NAME OF REGISTRAR E. Talbvert, Md.		25C. FUNERAL DIRECTOR Nutter Funeral Home	
25D. ADDRESS 3035 W. North Ave.					



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="float: right;">69 12703</span>	
<div style="display: flex; justify-content: space-between;"> <span>69 12703</span> <span>CERTIFICATE OF DEATH</span> </div>					
BIRTH NO. 1. NAME OF DECEASED (Type or Print) <b>John B. Jones</b>			2. DATE AND HOUR OF DEATH <b>12-17-69</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>5232 Denmore Avenue Baltimore, Maryland</b>			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <b>Maryland</b> 8. COUNTY <b>2788</b> C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>5232 Denmore Avenue</b>		
5. SEX <b>M</b>	6. RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11-10-97</b>	9. AGE (In years last birthday) <b>72</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Chauffeur</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Robert S. Green Contractor</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>Jashua Jones</b>			14. MOTHER'S MAIDEN NAME <b>Rebecca ? ?</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>218-07-0707</b>		17. INFORMANT ADDRESS <b>Mrs. Elsie B. Jones 5232 Denmore Avenue</b>	
18. <b>195.0 I</b> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (A) IMMEDIATE CAUSE <b>Metastatic malignant</b> DUE TO, OR AS A CONSEQUENCE OF: (B) <b>Intraabdominal malignancy</b> DUE TO, OR AS A CONSEQUENCE OF: (C) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Several months</b> <b>Several months</b>					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 19A. DATE OF OPERATION <b>0</b> 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) <b>NO</b> 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> 21F. HOW DID INJURY OCCUR? 22. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <b>Nov 19 69</b> to <b>Dec 17 19 69</b> that (I) ( <del>was</del> ) last saw the deceased alive on <b>Dec 17 19 69</b> and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>was</del> ) (did) (did not) view the body after death. 23A. SIGNATURE <b>Seymour Rubin</b> DEGREE <b>M.D.</b> 23B. DATE SIGNED <b>12/19/69</b> 23C. PHYSICIAN'S NAME (Type) <b>Seymour Rubin</b> 23D. ADDRESS <b>5415 Park Height Ave.</b> 24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b> 24B. DATE <b>12-22-69</b> 24C. NAME OF CEMETERY or CREMATORY <b>Carver Memorial Park</b> 24D. LOCATION (City, town, or county) (State) <b>Laurel, Maryland</b> 25A. DATE REC'D BY HEALTH DEPT. <b>DEC 24 1969</b> 25B. NAME OF REGISTRAR <b>Robert E. Taylor MD.</b> 25C. FUNERAL DIRECTOR ADDRESS <b>Nutter Funeral Home 3035 W. North Ave.</b>					



69 12704

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

69 12704

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>WILLIAM LAWRENCE</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour <b>12 12 69 9:10 a.m.</b>	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>1411 Mc Culloh St.</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>December 12, 1969 9:10 a.m.</b>	
5. USUAL RESIDENCE (Where deceased lived, if Institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>1402</b>			
6. SEX <b>Male</b>	7. RACE <b>Negro</b>	B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	C. CITY OR TOWN <b>Balto.</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
9. DATE OF BIRTH <b>11-6-04</b>	10. AGE (In years last birthday) <b>65</b>	E. STREET AND NUMBER <b>1411 McCulloh St.</b>	
11. BIRTHPLACE (State or foreign country) <b>North Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Oscar Lawrence</b>			
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Bar Tender</b>		14B. KIND OF BUSINESS OR INDUSTRY <b>Pride of Balto. Lodge</b>	
15. MOTHER'S MAIDEN NAME <b>Ida Macklin</b>			
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		17. SOCIAL SECURITY NO. <b>-</b>	
18. INFORMANT <b>Miss Ethel Lawrence</b>		ADDRESS <b>Norfolk, 3052 Schooly Ave. Va.</b>	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>412.24250.9</b> <b>Arteriosclerotic and hypertensive cardiovascular disease</b>		CAUSE OF DEATH APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>disease</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>Diabetes mellitus</b>		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:  (B) DUE TO, OR AS A CONSEQUENCE OF:  (C) DUE TO, OR AS A CONSEQUENCE OF:	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>Diabetes mellitus</b>			
20A. DATE OF OPERATION <b>12-16-69</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>no</b>	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>no</b>	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? <b>no</b>			
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) <b>no</b>		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR? <b>no</b>			
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <b>Isidore Mihalakis, M.D.</b> M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) <b>Isidore Mihalakis, M.D.</b> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <b>12/12/69</b> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>12-16-69</b>	24C. NAME OF CEMETERY OR CREMATORY <b>Mt Auburn Cemetery</b>	24D. LOCATION (City, town, or county) (State) <b>Baltimore Md</b>
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 24 1969</b>		25B. NAME OF REGISTRAR <b>Robert E. Galt, M.D.</b>	
25C. FUNERAL DIRECTOR <b>Nutter Funeral Home</b>		ADDRESS <b>3035 W. North Ave.</b>	

ACADEMIC RECORD

APPENDIX

VOLUME 1

1950

1951

1952

1953

1954

FUNERAL DIRECTOR: IMPORTANT

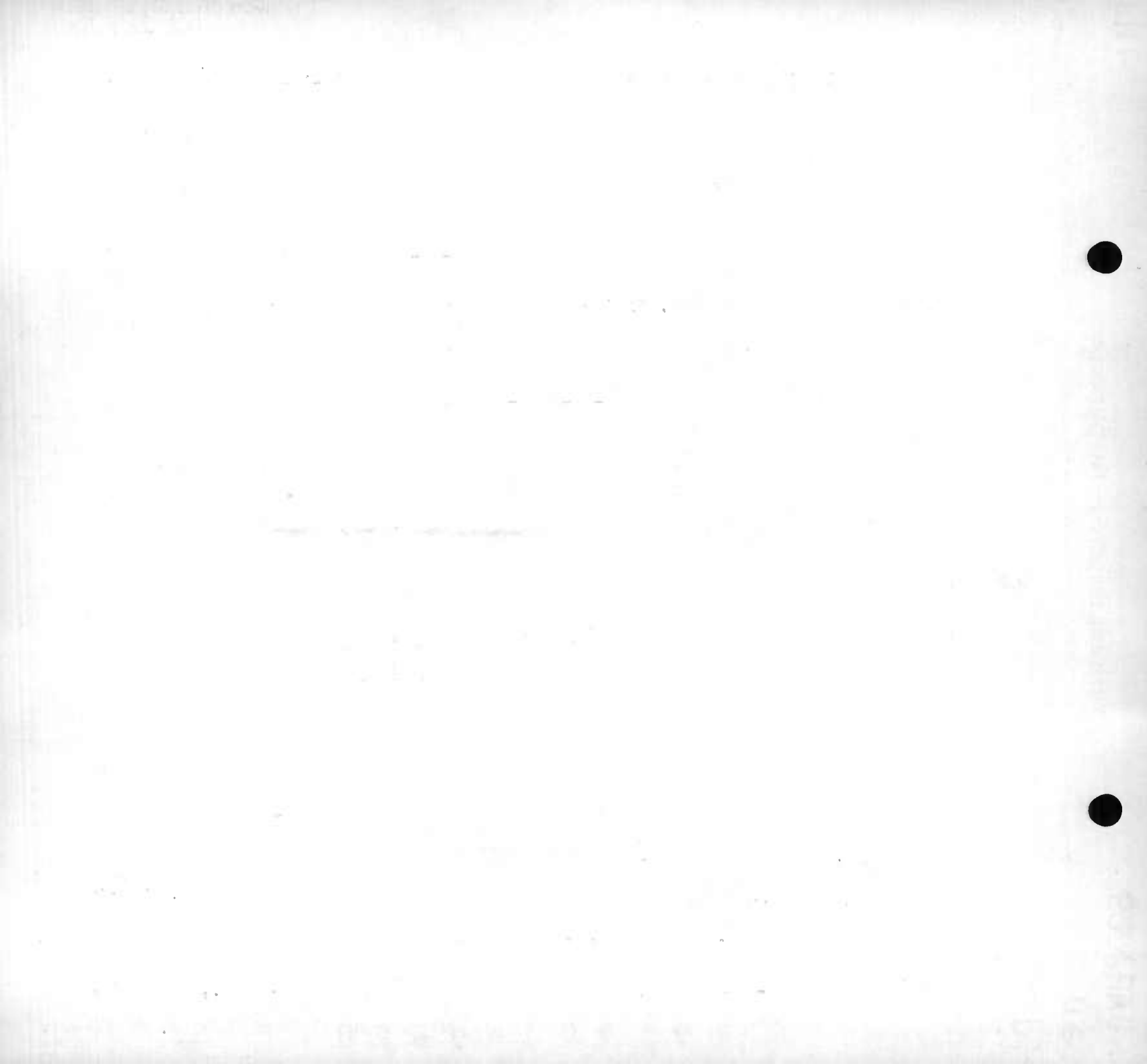
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-1521

# 69 12705 CERTIFICATE OF DEATH

REG. NO. 69 12705

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>Mattie Holmes Bevans</b>		2. DATE AND HOUR OF DEATH <b>12-19-69</b>   <b>9:30</b> P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>2019 Mc Culloh Street</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>1403</b>		
5. SEX <b>F</b>		6. RACE <b>N</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <b>11-27-78</b>		9. AGE (In years last birthday) <b>91</b>		If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Domestic Worker</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>Pvt. Family</b>		11. BIRTHPLACE (State or foreign country) <b>Richmond, Virginia</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			13. FATHER'S NAME <b>Walter Holmes</b>		
14. MOTHER'S MAIDEN NAME <b>Mattie ? ?</b>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		
16. SOCIAL SECURITY NO. <b>050-16-1909-A</b>		17. INFORMANT ADDRESS <b>Mr. Mason Bevans 2019 Mc Culloh Street</b>			
18. CAUSE OF DEATH <b>412.4 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Arteriosclerotic Cardiovascular Dis.</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:</b> <b>(B) DUE TO, OR AS A CONSEQUENCE OF:</b> <b>(C) DUE TO, OR AS A CONSEQUENCE OF:</b>					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>II</b> <b>Congestive Heart Failure</b>					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>18 DEC 1969</b> to <b>19 DEC 1969</b> , that (I) (we) last saw the deceased alive on <b>18 DEC 1969</b> and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Richard F. Tyson</b> 23C. PHYSICIAN'S NAME (Type) <b>Richard F. Tyson M.D.</b>				23B. DATE SIGNED <b>12-22-69</b> 23D. ADDRESS <b>2320 Eutaw Place Baltimore Maryland</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12-23-69</b>		24C. NAME OF CEMETERY or CREMATORY <b>Mt. Calvary Cemetery</b>	
24D. LOCATION (City, town, or county) (State) <b>Arrundel Co., Md</b>		25A. DATE REC'D BY HEALTH DEPT. <b>19690000</b>			
25B. NAME OF REGISTRAR <b>19690000</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Nutter Funeral Home 3035 W. North Ave.</b>			





This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				69 12706		69 12706	
BIRTH NO.				69 12706		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
Elsie Riddick Jennette				12-19-69		6:50 A. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION  37 MERCY HOSPITAL				A. STATE MARYLAND B. COUNTY BALTIMORE			
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER 1903 DUKELAND STREET							
5. SEX FEMALE		6. RACE NEGRO		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6-14-00	
9. AGE (in years last birthday) 69		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Presser		10B. KIND OF BUSINESS OR INDUSTRY Cleaning Co.		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME LOUIS LACKMAN		14. MOTHER'S MAIDEN NAME MARY E. Bulter			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or, unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 217-09-5080A		17. INFORMANT ADDRESS Mrs. Mabel Braxton 2527 Woodbrook Ave.			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 236.91 CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH A. IMMEDIATE CAUSE Bronchopneumonia DUE TO, OR AS A CONSEQUENCE OF: B. mixed mullerian DUE TO, OR AS A CONSEQUENCE OF: Tumour C.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION 211.17.69		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Hepatorenal Mass		20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) X		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) X		21C. WHERE DID INJURY OCCUR? X		(If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) A		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? X			
22. I certify that (I) (this hospital) attended the deceased from 11-13-1969 to 12-19-1969 that (I) (we) last saw the deceased alive on 12-18-1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Randhir P. Sinha, M.B.B.S. MD DEGREE						23B. DATE SIGNED 12-19-69	
23C. PHYSICIAN'S NAME (Type) RANDHIR P. SINHA, M.B.B.S. MD DEGREE						23D. ADDRESS Mercy Hospital Balto md 21202	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12-23-69		24C. NAME OF CEMETERY OR CREMATORY Carver Memorial Park		24D. LOCATION (City, town, or county) (State) Laurel, Maryland	
25A. DATE REC'D BY HEALTH DEPT. DEC 24 1969		25B. NAME OF REGISTRAR Robert E. Jaber, MD		25C. FUNERAL DIRECTOR ADDRESS Nutter Funeral Home 3035 W. North Ave.			



1  
J-635

## BALTIMORE CITY HEALTH DEPARTMENT

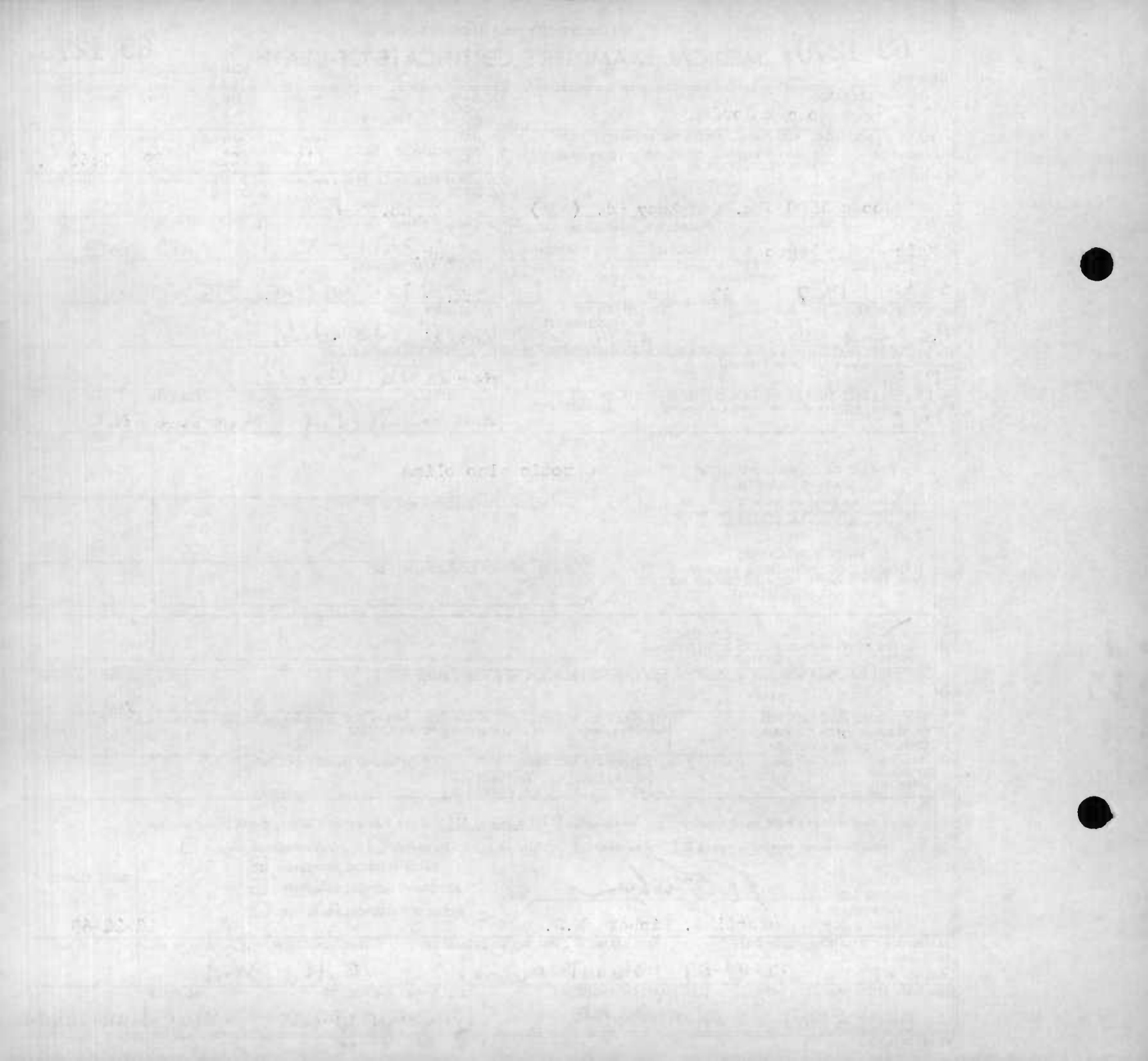
## 69 12707 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

69 12707

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Robert Jordan		2. DATE OF DEATH Known <input type="checkbox"/> Estimated <input type="checkbox"/>		Month	Day	Year	Hour
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 20 Woods 4500 blk. Pen Lucy Rd. (DOA)		3. DATE PRONOUNCED DEAD Month		Day	Year	Hour	M.
6. SEX Male		7. RACE Negro		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Unk. Md	
9. DATE OF BIRTH Sept. 14 - 1909		10. AGE (In years lost birthday) 62		11. BIRTHPLACE (State or foreign country) Manson, N.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Robert Jordan		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		15. MOTHER'S MAIDEN NAME Henrietta Goode		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) NO	
17. SOCIAL SECURITY NO.		18. INFORMANT William Jordan		19. ADDRESS Manson, N.C.		20. CAUSE OF DEATH Chronic alcoholism	
21. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) 303.2		22. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		23. (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Chronic alcoholism (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) yes			
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?			
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <u>R. Fisher</u> M.D. CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> EXAMINER'S NAME (Type) Russell S. Fisher, M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 12-22-69							
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12-24-69		24C. NAME OF CEMETERY or CREMATORY Mount Auburn		24D. LOCATION (City, town, or county) (State) Baltimore Md	
25A. DATE REC'D BY HEALTH DEPT. DEC 24 1969		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.		25C. FUNERAL DIRECTOR Morton Dyett		ADDRESS 1701 Laurens St	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				69 12708
69 12708		CERTIFICATE OF DEATH		REG. NO. 69 12708
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>SIDNEY DANIEL CURTIS</b>		2. DATE AND HOUR OF DEATH <b>12/22/69</b> <b>11:15 PM</b>
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION <b>CHS Hospital</b> <b>35</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY C. CITY OR TOWN <b>BALTO</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>821 North Aisquith Street</b>		
5. SEX <b>M</b>	6. RACE <b>N</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 12, 32</b>	9. AGE (In years last birthday) <b>37</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Unemployed</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>NORTH CAROLINA</b>
13. FATHER'S NAME <b>WILLIAM CURTIS</b>		14. MOTHER'S MAIDEN NAME <b>MARY JANE</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO.	17. INFORMANT <b>Thelma Curtis 821 N. Aisquith St.</b>	
18. <b>250.0 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>Cardiac Arrest</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:</b> <b>Diabetic mellitus &amp; Kib. Arteriosclerosis</b> <b>(B) DUE TO, OR AS A CONSEQUENCE OF:</b> <b>Chronic Pancreatitis &amp; Sepsis</b> <b>(C)</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <input checked="" type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <b>12/22/1969</b> 19 to <b>12/22/1969</b> 19 that (I) (we) last saw the deceased alive on <b>12/22/1969</b> 19 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <b>[Signature]</b>				23B. DATE SIGNED
23C. PHYSICIAN'S NAME (Type) <b>FILBERT</b>		23D. ADDRESS <b>140</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>12-27-1969</b>	24C. NAME OF CEMETERY or CREMATORY <b>Mt. Auburn Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 24 1969</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor, M.D.</b>		25C. FUNERAL DIRECTOR <b>1735 Harford Ave. ADDRESS Marshall W. Jones, Jr.</b>



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-650 69 12709		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 69 12709	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Julia Brown</i>		2. DATE AND HOUR OF DEATH <i>Dec 20 1969 7:45 p.m.</i>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>1901</i>		C. CITY OR TOWN <i>Baltimore</i> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION <i>Johns Hopkins Hospital</i> <i>133</i>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		E. STREET AND NUMBER <i>311-71 Calhoun St</i>	
5. SEX <i>Female</i>	6. RACE <i>Negro</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>12-29-88</i>	9. AGE (In years last birthday) <i>80</i>	10. Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Virginia</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>Isaac Armstrong</i>		14. MOTHER'S MAIDEN NAME <i>Fannie Hartney</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>219-323-0588A</i>		17. INFORMANT <i>Edna Welche - 311 N. Calhoun St</i>	
18. <i>431.9 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>INTRACEREBRAL INFARCTION</i> (B) <i>INTRACEREBRAL HEMORRHAGE</i> DUE TO, OR AS A CONSEQUENCE OF: (C) <i>CVA</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>24 HR</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>No</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) 1 Year (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <i>12-18</i> 19 <i>69</i> to <i>12-20</i> 19 <i>69</i> that (I) <input checked="" type="checkbox"/> last saw the deceased alive on <i>12-20</i> 19 <i>69</i> and that (in my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above. (I) <input checked="" type="checkbox"/> (did) <input checked="" type="checkbox"/> view the body after death.					
23A. SIGNATURE <i>N.F. Adkinson, Jr. MD</i>				23B. DATE SIGNED <i>12-20-69</i>	
23C. PHYSICIAN'S NAME (Type) <i>N.F. ADKINSON, JR. M.D.</i>				23D. ADDRESS <i>JOHNS HOPKINS HOSPITAL</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>12-27-69</i>		24C. NAME OF CEMETERY OR CREMATORY <i>CNT. AUBURN CEMETERY</i>	
24D. LOCATION <i>Baltimore, Maryland</i>		24E. CITY, TOWN, OR COUNTY <i>Baltimore</i>		24F. STATE <i>Maryland</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>DEC 24 1969</i>		25B. NAME OF REGISTRAR <i>Robert E. Taylor, M.D.</i>		25C. FUNERAL DIRECTOR <i>Charles R. Law</i>	
25D. ADDRESS <i>802 Madison Ave.</i>					

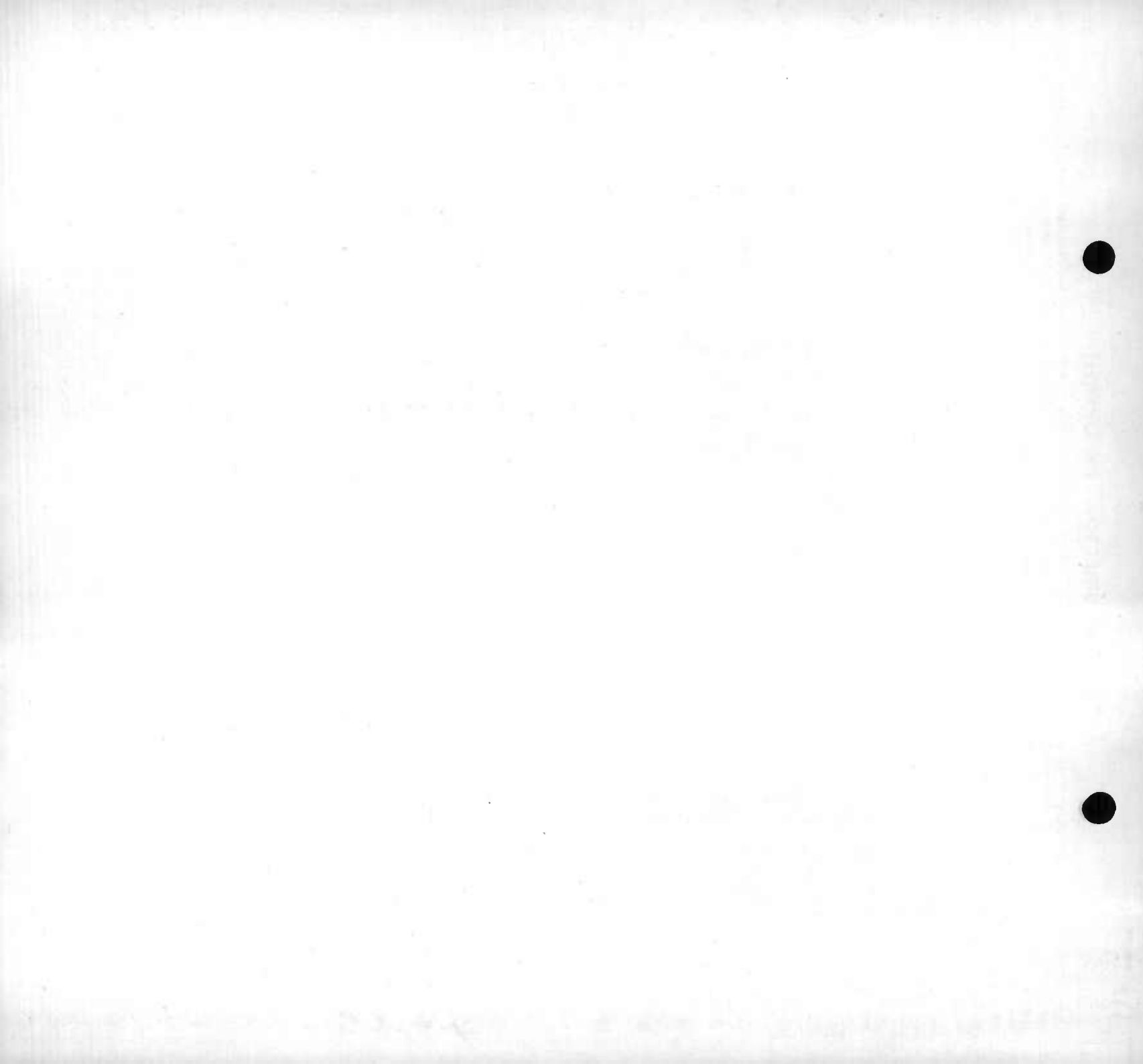




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

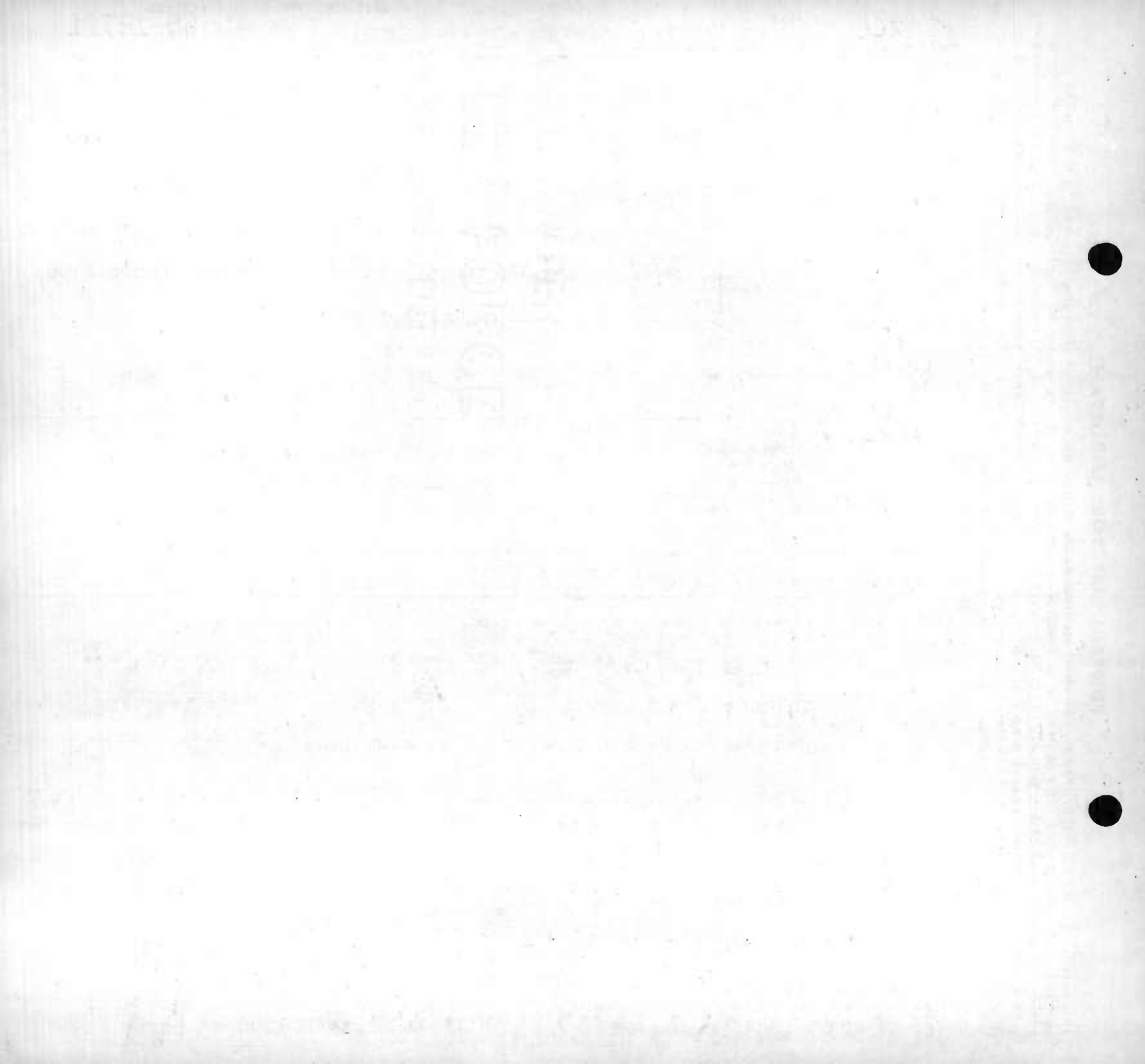
S-512		69 12710		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 69 12710	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) <i>James Sampson</i>			
2. DATE AND HOUR OF DEATH <i>Dec. 18, 1969 9:30 A.M.</i>							
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE <i>Maryland</i>		B. COUNTY <i>1547</i>	
<i>00 3308 Windsor Avenue</i>				C. CITY OR TOWN <i>Baltimore</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <i>3308 Windsor Ave</i>			
5. SEX <i>Male</i>	6. RACE <i>Colored</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Nov. 23, 1903</i>	9. AGE (In years last birthday) <i>66</i>	If Under 1 Yr. Months: Days: Hours: Min.	If Under 24 Hrs. Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Laborer</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Contractor</i>		11. BIRTHPLACE (State or foreign country) <i>Clinton, N. Carolina</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>James Sampson</i>				14. MOTHER'S MAIDEN NAME <i>Maggie Hicks</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>NO</i>		16. SOCIAL SECURITY NO. <i>213-14-3978</i>		17. INFORMANT <i>Mrs. Savannah Miller</i>		ADDRESS <i>3308 Windsor Ave</i>	
18. CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Ca. of Lung</i>		<i>6 months</i>	
				(B) <i>Ca. of Lung</i> DUE TO, OR AS A CONSEQUENCE OF:		<i>6 months</i>	
				(C) _____			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>12/1/69</i> to <i>12/1/69</i> 19 <i>69</i> to <i>12/1/69</i> 19 <i>69</i> , that (I) (we) last saw the deceased alive on <i>12/1/69</i> 19 <i>69</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>H. C. Burwell M.D.</i>				23B. DATE SIGNED <i>12/2/69</i>			
23C. PHYSICIAN'S NAME (Type) <i>H. C. Burwell M.D.</i>				23D. ADDRESS <i>1924 W. North Ave.</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>12/2/69</i>		24C. NAME OF CEMETERY or CREMATORY <i>Arbutus Memorial Park</i>		24D. LOCATION (City, town, or county) (State) <i>Arbutus Md</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>DEC 26 1969</i>		25B. NAME OF REGISTRAR <i>Robert E. Taylor</i>		25C. FUNERAL DIRECTOR <i>Joseph S. Miller</i>		ADDRESS <i>2222 W. North Ave.</i>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <b>69 12711</b>	
BIRTH NO. <b>H-400</b>		<b>69 12711</b>		<b>CERTIFICATE OF DEATH</b>	
1. NAME OF DECEASED (Type or Print) <b>MARY HOLLOWAY</b>			2. DATE AND HOUR OF DEATH <b>12/19/69</b> <b>3 A.</b> M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>90 KENSON NURSING HOME</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>1606</b> C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>2922 Arunah Ave</b>		
5. SEX <b>F</b>	6. RACE <b>C</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday) <b>85</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Calvert Co. Md</b>	
13. FATHER'S NAME <b>Unknown</b>			14. MOTHER'S MAIDEN NAME <b>Unknown</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mrs W A C Hughes</b> , ADDRESS	
18. <b>412.4 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <b>Chronic Cardio-Vascular Disease</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. <b>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:</b> <b>(B) DUE TO, OR AS A CONSEQUENCE OF:</b> <b>(C) DUE TO, OR AS A CONSEQUENCE OF:</b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 years.</b>		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <b>0 NONE</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO.</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>Jan. 2, 1968</b> to <b>Dec. 19, 1969</b> , that (I) (we) last saw the deceased alive on <b>Dec. 18, 1969</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Frank N. Ogoen, M.D.</b>			23B. DATE SIGNED <b>Dec. 20, 1969.</b>		Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>
23C. PHYSICIAN'S NAME (Type) <b>FRANK N. OGOEN, M.D.</b>			23D. ADDRESS <b>2701 N. CALVERT ST.</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>12/25/69</b>	24C. NAME of CEMETERY or CREMATORY <b>Mt Auburn Cemetry</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore M.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 26 1969</b>		25B. NAME OF REGISTRAR <b>Robert E. Fisher, R.D.</b>		25C. FUNERAL DIRECTOR <b>6 Halstead</b> ADDRESS <b>1206 W north Ave</b>	



REG. NO.

69 12712

VS 151-REV. 7/1/68

N 949.0

ACADEMY BOOK

WATKINS & CO.

100 N. 3rd St.

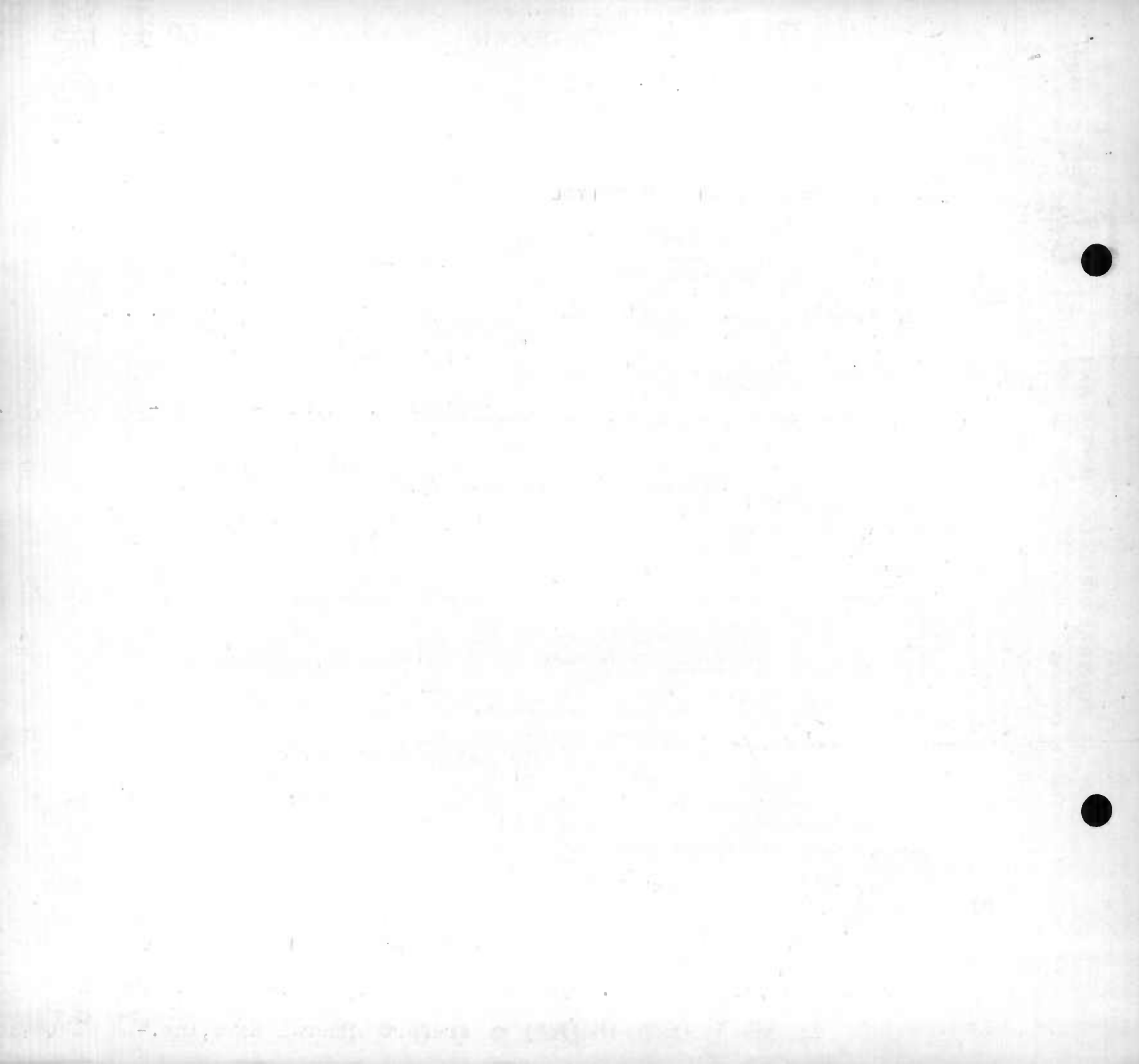
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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <b>69 12713</b>	
C240 69 12713					
BIRTH NO.				2. DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print) <b>MARY G. CHISLEY</b>				<b>12-19-69 9:00 A. M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>33 THE JOHNS HOPKINS HOSPITAL</b>				A. STATE <b>MARYLAND</b> B. COUNTY <b>CHARLES</b> <b>5800</b>	
				C. CITY OR TOWN <b>LA PLATA</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
				E. STREET AND NUMBER	
5. SEX <b>FEMALE</b>	6. RACE <b>NEGRO</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10-29-21</b>		9. AGE (In years lost birthday) <b>48</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Wife</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>at Home</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>					
13. FATHER'S NAME <b>JOHN BOWMAN</b>			14. MOTHER'S MAIDEN NAME <b>ADA BROWN</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <b>James M. Chisley-Husband-La Plata, Md.</b>	
18. CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
18A. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>230.4</b>				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Myocardial Infarct</b>	
18B. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b>				(B) DUE TO, OR AS A CONSEQUENCE OF: <b>Persistent Hemorrhage</b>	
				(C) <b>Removal of Rectal tumor</b>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				<b>Blood coagulopathy</b>	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>Dec 12/19 1969</b> to <b>12/19 1969</b> , that (I) (we) last saw the deceased alive on <b>12/19 1969</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Walter S. Smith MD</b>				23B. DATE SIGNED <b>12/19/1969</b>	
23C. PHYSICIAN'S NAME (Type) <b>Walter S. Smith MD</b>				23D. ADDRESS <b>THE JOHNS HOPKINS HOSPITAL</b>	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
<b>Burial</b>		<b>12/23/1969</b>		<b>St. Catherin's Cemetery McConchie, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
<b>DEC 26 1969</b>		<b>Robert E. Taylor, MD</b>		<b>Arellano Funeral Home, Inc.-La Plata, Md.</b>	



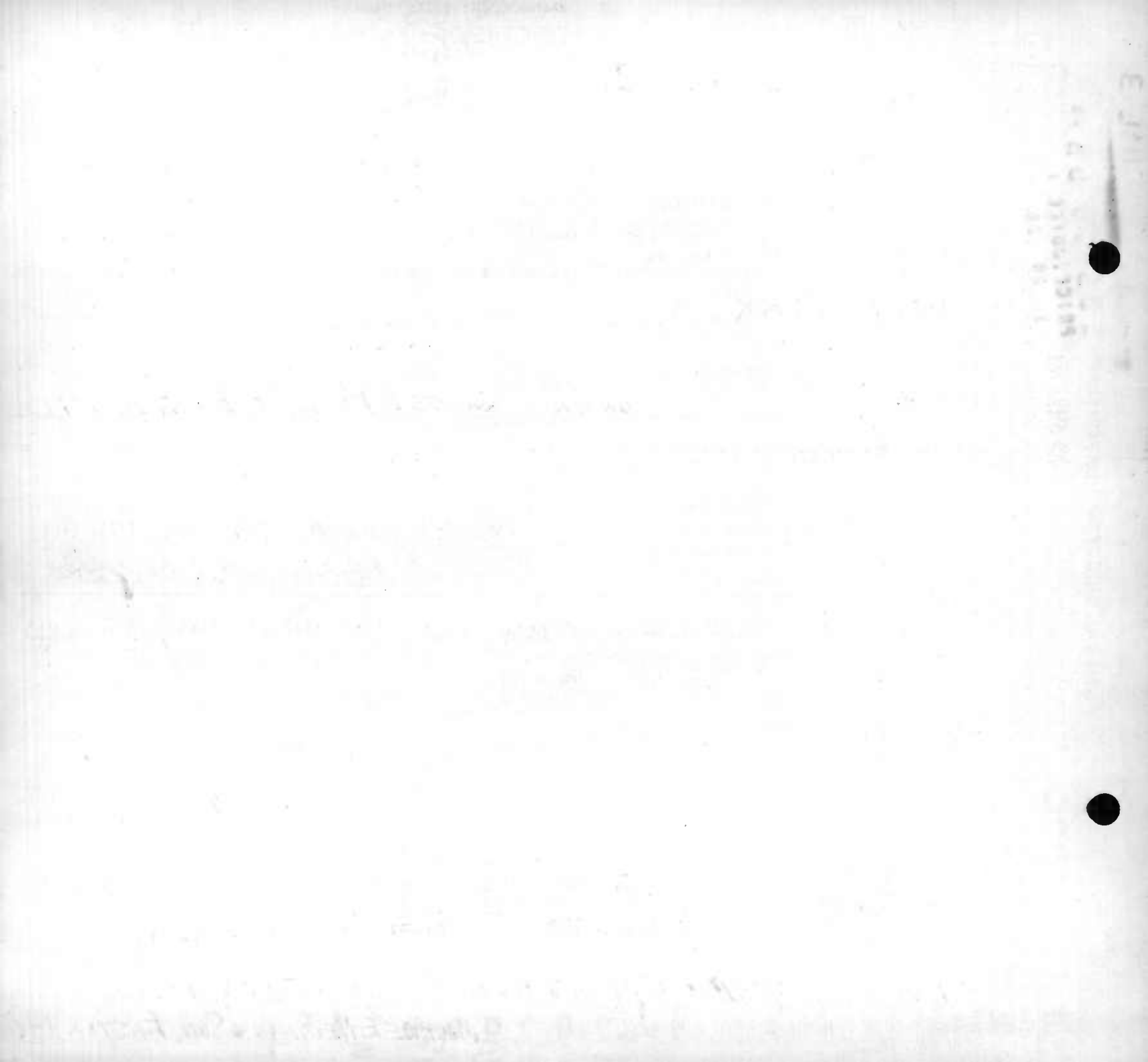




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

P620 69 12714		BALTIMORE CITY HEALTH DEPARTMENT		X REG. NO. 69 12714	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) PRICE, JOYCE I.		2. DATE AND HOUR OF DEATH 12/21/69 950 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY TALBOT		7029	
FULL NAME OF HOSPITAL OR INSTITUTION 33 JOHNS HOPKINS HOSPITAL 601 N. BROADWAY, BALTO.		C. CITY OR TOWN EASTON		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER 514 GODSBORO ST.			
5. SEX F	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/28/28	9. AGE (In years last birthday) 41	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWORK		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME William Paluck		14. MOTHER'S MAIDEN NAME Agnes Zelanye	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. UNKN.		17. INFORMANT JAMES E. PRICE, SR. EASTON, MD.	
18. 4428		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: CARDIAC ARREST			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF: Probable pulmonary embolus		10 min.	
		(C) <del>Coronary artery disease</del>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		Craniotomy for aneurysm		15 days.	
19A. DATE OF OPERATION 3/12/69		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Aneurysm cerebral		20A. AUTOPSY? (Yes or No) Yes	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? NO		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (1) (this hospital) attended the deceased from 12/19 1969 to 12/21 1969, that (1) (we) last saw the deceased alive on 12/21 1969 and that (1) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Charles Burton, M.D.		23B. DATE SIGNED 12/22/69		23C. PHYSICIAN'S NAME (Type) CHARLES BURTON, M.D.	
23D. ADDRESS JOHNS HOPKINS HOSPITAL		24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 12/24/1969	
24C. NAME OF CEMETERY OR CREMATORY SPRING HILL		24D. LOCATION (City, town, or county) (State) EASTON, MD		25A. DATE REC'D BY HEALTH DEPT. DEC 26 1969	
25B. NAME OF REGISTRAR Maurice E. Newman		25C. FUNERAL DIRECTOR Maurice E. Newman		25D. ADDRESS Easton, MD	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

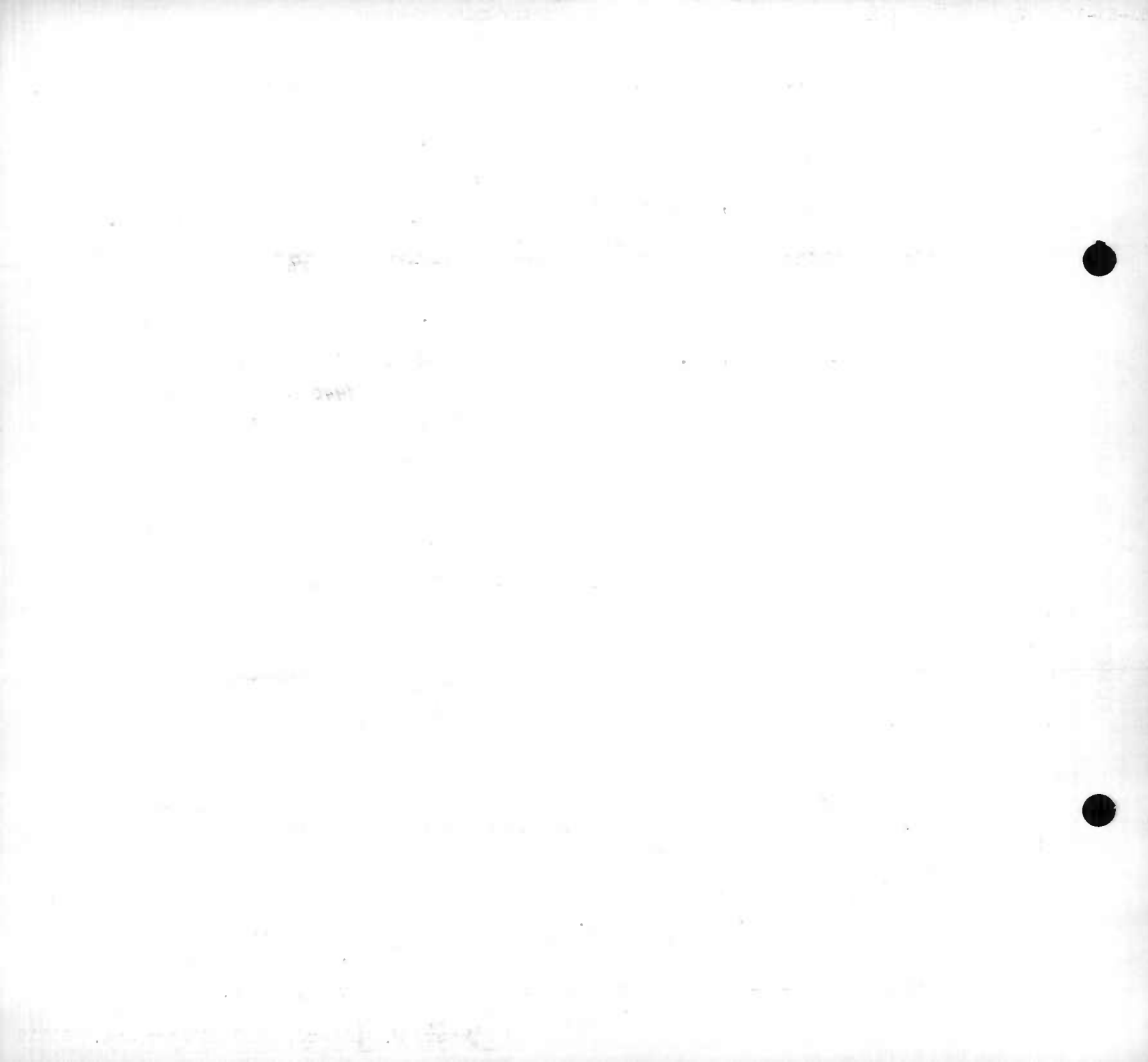
M460 69 12715		BALTIMORE CITY HEALTH DEPT <b>CERTIFICATE OF DEATH</b>		REG. NO. 69 12715	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Miller Lottie</i>		2. DATE AND HOUR OF DEATH <i>12/20/69 1 2<sup>00</sup> A.M.</i>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>704</i>		C. CITY OR TOWN <i>Baltimore</i>	
FULL NAME OF HOSPITAL OR INSTITUTION <i>90 MT. Sinai Nursing Home, Inc</i> <i>4613 Park Heights Avenue</i>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <i>7</i>		6. RACE <i>N</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <i>10/25/00</i>		9. AGE (In years lost birthday) <i>69 years</i>		If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>LABOR</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>VARIOUS</i>		11. BIRTHPLACE (State or foreign country) <i>MARYLAND</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>		13. FATHER'S NAME <i>ELLS CLAYTON</i>		14. MOTHER'S MAIDEN NAME <i>EMMA</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>NO</i>		16. SOCIAL SECURITY NO. <i>014-58-5902</i>		17. INFORMANT <i>Medical Records - Nursing Home</i>	
18. <i>402X1</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>Cerebral Thrombosis</i> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Hypertensive Heart Disease</i> (B) DUE TO, OR AS A CONSEQUENCE OF: <i>none</i> (C) <i>none</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>3 weeks</i> <i>2 years</i>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>no</i>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) <del>this</del> hospital attended the deceased from <i>Nov 1</i> 19 <i>69</i> to <i>DEC 20</i> 19 <i>69</i> , that (I) <del>was</del> last saw the deceased alive on <i>DEC 20</i> 19 <i>69</i> and that in (my) <del>last</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>was</del> (did) <del>not</del> view the body after death.					
23A. SIGNATURE <i>Manuel Levin</i>		Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <i>12/20/69</i>	
23C. PHYSICIAN'S NAME (Type) <i>MANUEL LEVIN</i>		23D. ADDRESS <i>MD 6101 PARK HTS AVE BALD - 15 MD</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i>		24B. DATE <i>12/24/69</i>		24C. NAME OF CEMETERY or CREMATORY <i>Union Cem.</i>	
24D. LOCATION (City, town, or county) <i>B.F.D. WORTON Kent. Md</i>					
25A. DATE REC'D BY HEALTH DEPT. <i>DEC 26 1969</i>		25B. NAME OF REGISTRAR <i>Robert E. Taylor MD.</i>		25C. FUNERAL DIRECTOR <i>Stearns</i> ADDRESS <i>Chester Town Md</i>	



## FUNERAL DIRECTOR: IMPORTANT

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T512 69 12716		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH X REG. NO. 69 12716	
BIRTH NO. 69 12716		1. NAME OF DECEASED (Type or Print) JAMES L. THOMPSON, JR.	
2. DATE AND HOUR OF DEATH 12-22-69 8:00 P.M.		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 31 (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) BALTIMORE CITY HOSPITALS 4940 Eastern Avenue Baltimore, Maryland 21224	
4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Penn. B. COUNTY Hazelton		C. CITY OR TOWN Hazelton D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER 1829 W. 5th Street Hazelton Penn.		5. SEX Male 6. RACE White 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 3-7-31 9. AGE (In years last birthday) 38		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 10B. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Penn.		12. CITIZEN OF WHAT COUNTRY USA	
13. FATHER'S NAME James L. Thompson, Sr.		14. MOTHER'S MAIDEN NAME <del>XXXXXXXX</del> Bessie Unis	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT ADDRESS 1940 Eastern Avenue BCH-Records Baltimore, Maryland 21224			
18. 206.01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH GRAM NEGATIVE SEPTICEMIA (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: ACUTE MONONUCLEOTIC LEUKEMIA (B) DUE TO, OR AS A CONSEQUENCE OF: BONE MARROW TRANSPLANT (C) DUE TO, OR AS A CONSEQUENCE OF:	
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 14 days 7 mos 52 days			
MEDICAL CERTIFICATION OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION 21. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20A. AUTOPSY? (Yes or No) 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21B. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21C. HOW DID INJURY OCCUR?	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>	
22. I certify that (this hospital) attended the deceased from 19 to 22 DEC 5 1969 that (we) lost saw the deceased alive on 22 DECEMBER 1969 and that (in our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) view the body after death.			
23A. SIGNATURE Daniel C. Hadlock MD DEGREE		23B. DATE SIGNED 22 Dec 1967	
23C. PHYSICIAN'S NAME (Type) DANIEL C. HADLOCK MD DEGREE		23D. ADDRESS 4940 Eastern Avenue BCH Baltimore, Maryland 21224	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12-26-1969	
24C. NAME OF CEMETERY OR CREMATORY Calvary Cemetery		24D. LOCATION (City, town, or county) (State) Durums, Penna.	
25A. DATE REC'D BY HEALTH DEPT. DEC 26 1969		25B. NAME OF REGISTRAR Robert E. Taylor, R.D.	
25C. FUNERAL DIRECTOR		ADDRESS Howard H. Hubbard, 4107 Wilkens Ave. 21229	



# FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <b>69 12717</b>	
<b>E324</b> <b>BIRTH NO. 69 12717</b>		<b>CERTIFICATE OF DEATH</b>			
<b>1. NAME OF DECEASED</b> (Type or Print) <b>Charles J. Etzel</b>			<b>2. DATE AND HOUR OF DEATH</b> <b>12-23-69</b>		
<b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b>  <b>FULL NAME OF HOSPITAL OR INSTITUTION</b> (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  <b>00 3133 Fait Avenue</b>			<b>4. USUAL RESIDENCE</b> (Where deceased lived: If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>101</b> <b>C. CITY OR TOWN</b> <b>Baltimore</b> <b>D. INSIDE CITY LIMITS?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> <b>E. STREET AND NUMBER</b> <b>3133 Fait Avenue</b>		
<b>5. SEX</b> <b>M</b>	<b>6. RACE</b> <b>W</b>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>11/22/03</b>	<b>9. AGE</b> (In years last birthday) <b>66</b>	<b>If Under 1 Yr.</b> Months: _____ Days: _____
<b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Ass't to Supt.</b>			<b>10B. KIND OF BUSINESS OR INDUSTRY</b> <b>Gas &amp; Electric</b>		
<b>11. BIRTHPLACE</b> (State or foreign country) <b>Baltimore, Maryland</b>			<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>		
<b>13. FATHER'S NAME</b> <b>John G. Etzel</b>			<b>14. MOTHER'S MAIDEN NAME</b> <b>Unknown</b>		
<b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>			<b>16. SOCIAL SECURITY NO.</b> <b>"rs. Johanna Etzel 3133 Fait Avenue</b>		
<b>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  <b>15-3-81</b> <b>CAUSE OF DEATH</b> <b>Carcinoma of Colon</b> <b>7 mos.</b>			<b>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</b>		
<b>19A. DATE OF OPERATION</b> <b>0</b>			<b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b>		
<b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner) <input type="checkbox"/>			<b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		
<b>21D. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (Approx.)			<b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		
<b>22. I certify that (I) (this hospital) attended the deceased from</b> <b>April 1 1969</b> <b>to</b> <b>December 23 1969.</b> <b>that (I) (we) last saw the deceased alive on</b> <b>Dec 23 1969</b> <b>and that in (my) (our) opinion death occurred on the date</b> <b>and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</b>			<b>20A. AUTOPSY?</b> (Yes or No)		
<b>23A. SIGNATURE</b> <b>Jason H. Gaskel M.D.</b>			<b>23B. DATE SIGNED</b> <b>12-23-69</b>		
<b>23C. PHYSICIAN'S NAME</b> (Type) <b>Jason H. Gaskel M.D.</b>			<b>23D. ADDRESS</b> <b>637 S. Conkling St. Baltimore, Md</b>		
<b>24A. BURIAL CREMATION, REMOVAL</b> (Specify) <b>Burial</b>			<b>24B. DATE</b> <b>12/26/69</b>		
<b>24C. NAME OF CEMETERY OR CREMATORY</b> <b>Sacred Heart Cemetery</b>			<b>24D. LOCATION</b> (City, town, or county) (State) <b>Baltimore, Maryland</b>		
<b>25A. DATE REC'D BY HEALTH DEPT.</b> <b>DEC 26 1969</b>			<b>25B. NAME OF REGISTRAR</b> <b>Robert E. Juba, M.D.</b>		
<b>25C. FUNERAL DIRECTOR</b> <b>John F. Moran, Inc.</b>			<b>ADDRESS</b> <b>3000 E. Baltimore St</b>		

James H. Gaskel

Dec 22 1891

James H. Gaskel MD  
12-22-91



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		REG. NO. <b>69 12718</b>	
BIRTH NO. <b>69 12718</b>				2. DATE AND HOUR OF DEATH <b>12/13/69 10:10 P.M.</b>			
1. NAME OF DECEASED (Type or Print) <b>Diane Elaine Hawkins</b>				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				A. STATE <b>Md</b> B. COUNTY <b>Balt.</b>		5300	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>University Hospital 30 Balt. Md.</b>				C. CITY OR TOWN <b>Owings Mills</b>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
				E. STREET AND NUMBER <b>Rosewood St. Hospital</b>			
5. SEX <b>F</b>	6. RACE <b>N N</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11/25/49</b>	9. AGE (In years last birthday) <b>20</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Md</b>		
12. CITIZEN OF WHAT COUNTRY? <b>US</b>							
13. FATHER'S NAME <b>Patrick Hawkins Jr.</b>				14. MOTHER'S MAIDEN NAME <b>Alverta Hamilton</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>			16. SOCIAL SECURITY NO. <b>No</b>		17. INFORMANT <b>Rosewood S.H. Owings Mills Md</b>		
18. <b>560.21</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE <b>Peritonitis</b> DUE TO, OR AS A CONSEQUENCE OF:		<b>4 Days</b>	
ANTECEDENT CAUSES				(B) <b>Septicemia</b> DUE TO, OR AS A CONSEQUENCE OF:		<b>4 Days</b>	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <b>12-1-69</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>trichobezoar 2. jejunal volvulus</b>		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from <b>11/29</b> 19 <b>69</b> to <b>12/13</b> 19 <b>69</b> that (I) (we) last saw the deceased alive on <b>12/13</b> 19 <b>69</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Nicholas C. Bosch MD</b>				23B. DATE SIGNED <b>12/13/69</b>			
23C. PHYSICIAN'S NAME (Type) <b>Nicholas C. Bosch</b>				23D. ADDRESS <b>Univ. of Maryland Hospital</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12-17-69</b>		24C. NAME of CEMETERY or CREMATORY <b>Union Bethel Ch. Cem.</b>		24D. LOCATION (City, town, or county) (State) <b>Braodysvine P. Geo. Co. Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 26 1969</b>		25B. NAME OF REGISTRAR <b>Robert E. Gaby, R.D.</b>		25C. FUNERAL DIRECTOR <b>Martell Adams Aquasco, Md.</b>		ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

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K455 69 12719 BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT <b>CERTIFICATE OF DEATH</b>		REG. NO. 69 12719	
1. NAME OF DECEASED (Type or Print) <u>Kleeman, Margaret</u>			2. DATE AND HOUR OF DEATH <u>12/21/69</u> <u>2:30</u> A.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Maryland General Hospital</u> <u>Baltimore, Maryland</u>			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>Baltimore</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>2100 Maryland Ave.</u>		
5. SEX <u>Fe</u>	6. RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1/2/88</u>	9. AGE (In years last birthday) <u>81</u>	10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Nurse</u>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Philadelphia</u>
13. FATHER'S NAME <u>William Johnson</u>			14. MOTHER'S MAIDEN NAME <u>?</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO.		17. INFORMANT <u>Robert Greisser</u> ADDRESS <u>9940 Hilltop Dr. Balt. MD.</u>
18. <u>45-1.91</u> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>Congestive Heart Failure</u>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>no</u>	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>12/15</u> 19 <u>69</u> to <u>12/21</u> 19 <u>69</u> that (I) (we) last saw the deceased alive on <u>12/21</u> 19 <u>69</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>M.L. Brown</u>			23B. DATE SIGNED <u>12/21/69</u>		23C. PHYSICIAN'S NAME (Type) <u>M.L.S. Brown</u>
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>			24B. DATE <u>12-23-69</u>		24C. NAME OF CEMETERY OR CREMATORY <u>CEDAR Bluff</u>
24D. LOCATION (City, town, or county) <u>Annapolis A.A. MD.</u>			25A. DATE REC'D BY HEALTH DEPT. <u>EC 26 1969</u>		
25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>			25C. FUNERAL DIRECTOR <u>John M. Taylor &amp; Sons Annapolis MD</u>		

William Johnson

no

Robert Grisser

and Hiltop Dr.  
Barto. Md.

ON RIAL 15-33-01 CEDAR BLVD

Amundson's

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MD.

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 68-12720	
<div style="display: flex; justify-content: space-between;"> <span>7645 68 12720</span> <span><b>CERTIFICATE OF DEATH</b></span> </div>					
1. NAME OF DECEASED (Type or Print) <b>James Ireland</b>			2. DATE AND HOUR OF DEATH <b>12-21-69 3:20 AM</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <b>Harbor View ncc</b>			A. STATE <b>MD</b> B. COUNTY <b>A.A. Co.</b>		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			C. CITY OR TOWN <b>EDGEWATER</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
<b>90</b>			E. STREET AND NUMBER <b>EDGEWATER P.O.</b>		
5. SEX <b>male</b>	6. RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8-10-06</b>	9. AGE (In years last birthday) <b>62</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Truck Driver</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Teueking</b>		11. BIRTHPLACE (State or foreign country) <b>Greenock, MD.</b>	
13. FATHER'S NAME <b>JAMES W. IRELAND</b>			14. MOTHER'S MAIDEN NAME <b>GERTRUDE BRADY</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>			16. SOCIAL SECURITY NO. <b>216-16-4961</b>		
17. INFORMANT <b>ELIZABETH E. IRELAND #4</b>			ADDRESS		
18. <b>4123 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>cerebral aneurysm - rupture</b> <b>11/2/69</b>		
			(B) <b>arteriosclerotic heart disease</b> <b>years</b>		
			(C) <b>arteriosclerosis</b> <b>years</b>		
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, locality, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>5/29</b> 19 <b>69</b> to <b>12/21</b> 19 <b>69</b> , that (I) (we) last saw the deceased alive on <b>12/21</b> 19 <b>69</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>ae M... MD</b>				23B. DATE SIGNED <b>12/21/69</b>	
23C. PHYSICIAN'S NAME (Type) <b>ALLAN H. M... MD</b>				23D. ADDRESS <b>2 E Red St Balt MD</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>12-23-69</b>		24C. NAME OF CEMETERY or CREMATORY <b>Mt. Zion</b>	
24D. LOCATION <b>Mt Zion A.A. MD.</b>		24E. (City, town, or county) (State)			
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 26 1969</b>		25B. NAME OF REGISTRAR <b>John E. Taylor MD</b>		25C. FUNERAL DIRECTOR <b>John E. Taylor MD</b>	
25D. ADDRESS		25E. ADDRESS			



# FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <b>69 12721</b>	
S410 69 12721		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <b>ELMER M. SELBY</b>		2. DATE AND HOUR OF DEATH <b>3:20 pm 12/19/69</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  <b>46 Luthers Hospitel.</b>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>1902</b>	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>46 Luthers Hospitel.</b>		C. CITY OR TOWN <b>Baltimore</b>	D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
		E. STREET AND NUMBER <b>124 S. Calhoun St.</b>	
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3-29-83</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Maintenance</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Chemical</b>	9. AGE (In years lost birthday) <b>86</b>
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Louis Henry Selby</b>		14. MOTHER'S MAIDEN NAME <b>Jane Giffin</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>215-07-7876</b>	17. INFORMANT <b>Elmer Mac (wife)</b>
		ADDRESS <b>same</b>	
18. <b>412.417-199.1</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE <b>AscVD &amp; Atrial fibrillation</b> DUE TO, OR AS A CONSEQUENCE OF: (B) <b>Chronic emphysema &amp; ob. &amp; ed. PI Effusion</b> DUE TO, OR AS A CONSEQUENCE OF: (C) <b>? Occult malignancy</b>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION <b>0</b>	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>12/15 1969</b> to <b>12/18 1969</b> , that (I) (we) lost saw the deceased alive on <b>3:20 pm 12/18 1969</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <b>R. Hestag</b>		23B. DATE SIGNED <b>12/19/69</b>	
23C. PHYSICIAN'S NAME (Type) <b>PRATIMA K HASTAGI</b>		23D. ADDRESS <b>Luthers Hospitel</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>12/23/69</b>	24C. NAME OF CEMETERY or CREMATORY <b>Moreland Mem. Park Cem.</b>	24D. LOCATION (City, town, or county) (State) <b>Baltimore Co., Maryland</b>
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 26 1969</b>	25B. NAME OF REGISTRAR <b>Robert S. Taylor, M.D.</b>	25C. FUNERAL DIRECTOR ADDRESS <b>Walters Funeral Home Pratt &amp; Stricker Sts.</b>	

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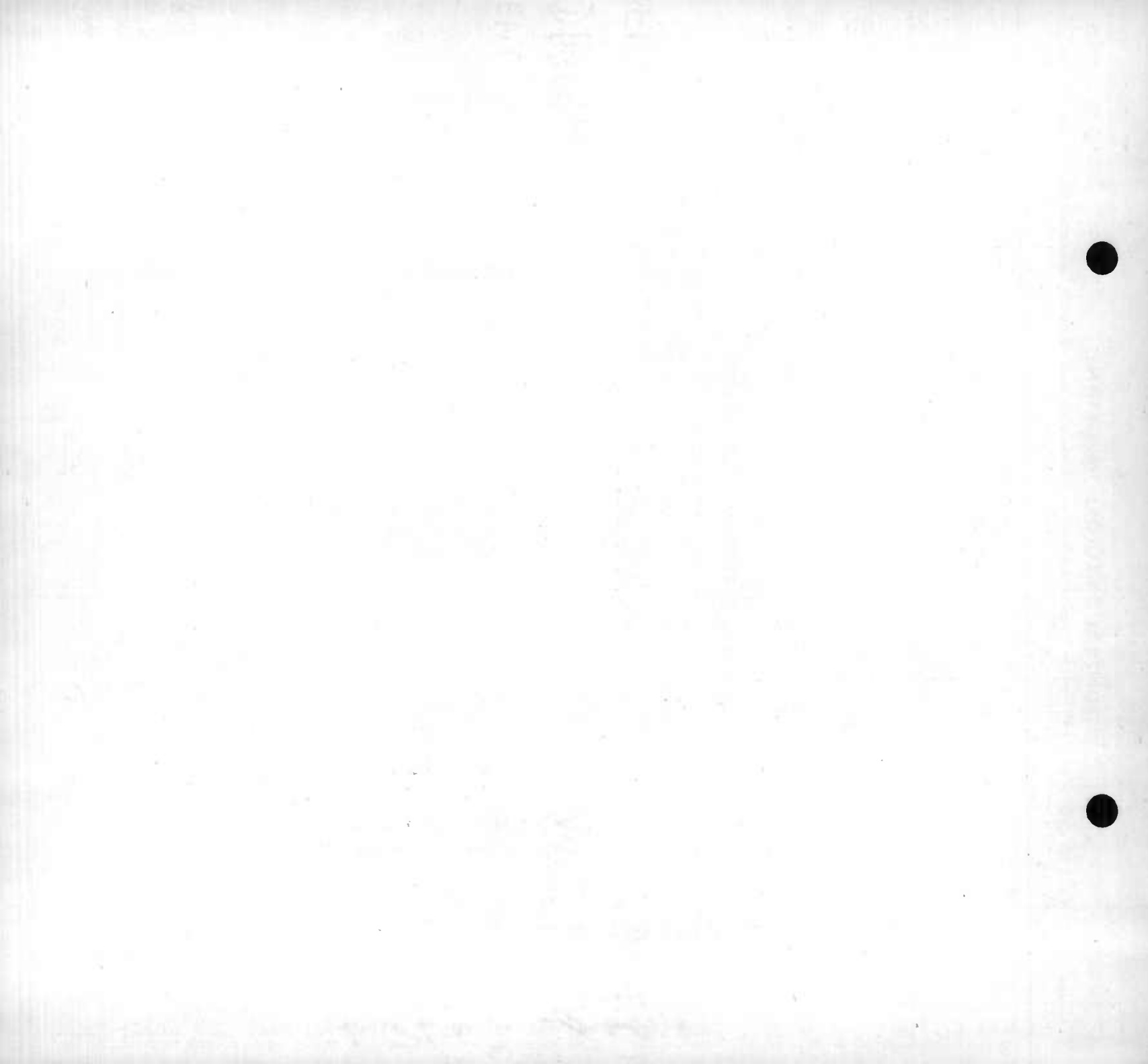
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B650 69 12722				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 69 12722	
1. NAME OF DECEASED (Type or Print) <b>BROWN, Walter</b>				2. DATE AND HOUR OF DEATH <b>Dec. 22, 1969</b> <b>2:45</b> <b>A.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>90 Bolton Hill Nursing &amp; Convalescent Ctr.</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>904</b> C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>2707 Greenmount Avenue</b>			
5. SEX <b>M</b>	6. RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11-17-04</b>	9. AGE (In years lost birthday) <b>65</b>	If Under 1 Yr. Months: _____ Days: _____	If Under 24 Hrs. Hours: _____ Min. _____	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Cab driver</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Taxicabs</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>XXXXXXXXX Walter Brown</b>				14. MOTHER'S MAIDEN NAME <b>Mary Klinefelter</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No.</b>		16. SOCIAL SECURITY NO. <b>217-01-7519</b>		17. INFORMANT ADDRESS <b>Mrs. Henry Becker 8628 Oakleigh Road, 21234</b>			
18. <b>CAUSE OF DEATH</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).  <b>Subdural Hematoma</b> <b>fractured skull</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>10/20/69</b> <b>10/20/69</b>			
19A. DATE OF OPERATION <b>10/20/69</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input checked="" type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Home</b>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>Balt City - 2707 Greenmount Ave ?!</b>			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) <b>10/20/69</b>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? <b>Fell down flight steps</b>			
22. I certify that (I) (this hospital) attended the deceased from <b>12/12/69</b> to <b>12/22/69</b> , that (I) (we) last saw the deceased alive on <b>12/12/69</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Dr. Alan Macht</b>				23B. DATE SIGNED <b>12/22/69</b>			
23C. PHYSICIAN'S NAME (Type) <b>Dr. Alan Macht</b>				23D. ADDRESS <b>2 E. Real St Balt Md 21002</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12/24/69</b>		24C. NAME OF CEMETERY or CREMATORY <b>Moreland Memorial Park</b>		24D. LOCATION (City, town, or county) (State) <b>Parkville, Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 26 1969</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor, M.D.</b>		25C. FUNERAL DIRECTOR ADDRESS <b>9117 Fitch Funeral Home 4210 Belair Road.</b>			



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT <b>CERTIFICATE OF DEATH</b>		REG. NO. <b>69 12723</b>	
1. NAME OF DECEASED (Type or Print) <b>IRVIN T. GARDNER</b>		2. DATE AND HOUR OF DEATH <b>DEC. 19, 1969</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>42 SINAI HOSPITAL</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MD.</b> B. COUNTY <b>Balta.</b> <b>53-00</b> C. CITY OR TOWN <b>ARBUTUS</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER <b>1216 MAIDEN CHOICE LANE</b>	
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>FEB. 2, 1912</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>ACCOUNTANT</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>SUN LIFE INSURANCE</b>	
11. BIRTHPLACE (State or foreign country) <b>MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>JAMES E. GARDNER</b>		14. MOTHER'S MAIDEN NAME <b>VERONICA OSTERLOCK</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>YES WW II</b>		16. SOCIAL SECURITY NO. <b>216-61-5837</b>	
17. INFORMANT <b>Mrs. Mary M. Gardner - 1216 Maiden Choice Lane</b>		ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>41019 I Myocardial infarction</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>Has been coming to office monthly visits</b>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Nov 1965</b> (B) DUE TO, OR AS A CONSEQUENCE OF: (C)	
19A. DATE OF OPERATION <b>none</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) <b>no</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <b>none</b>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) <b>11/11 1969</b>	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>Nov 1965</b> 19 to <b>Nov 11</b> 19 <b>69</b> , that (I) (we) last saw the deceased alive on <b>11/11</b> 19 <b>69</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <b>George McLean</b>		23B. DATE SIGNED <b>12/20/69</b>	
23C. PHYSICIAN'S NAME (Type) <b>GEORGE MCLEAN</b>		23D. ADDRESS <b>705 Med. Arts Bldg Balt Md</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12-22-69</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Cathedral Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 26 1969</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor, M.D.</b>	
25C. FUNERAL DIRECTOR <b>W. J. G. Gorman, B.S.M., Cathedral Q.M.</b>		ADDRESS	

George McLean  
1912

The same as the one in the  
1912

1911

1912



George McLean

GEORGE McLEAN

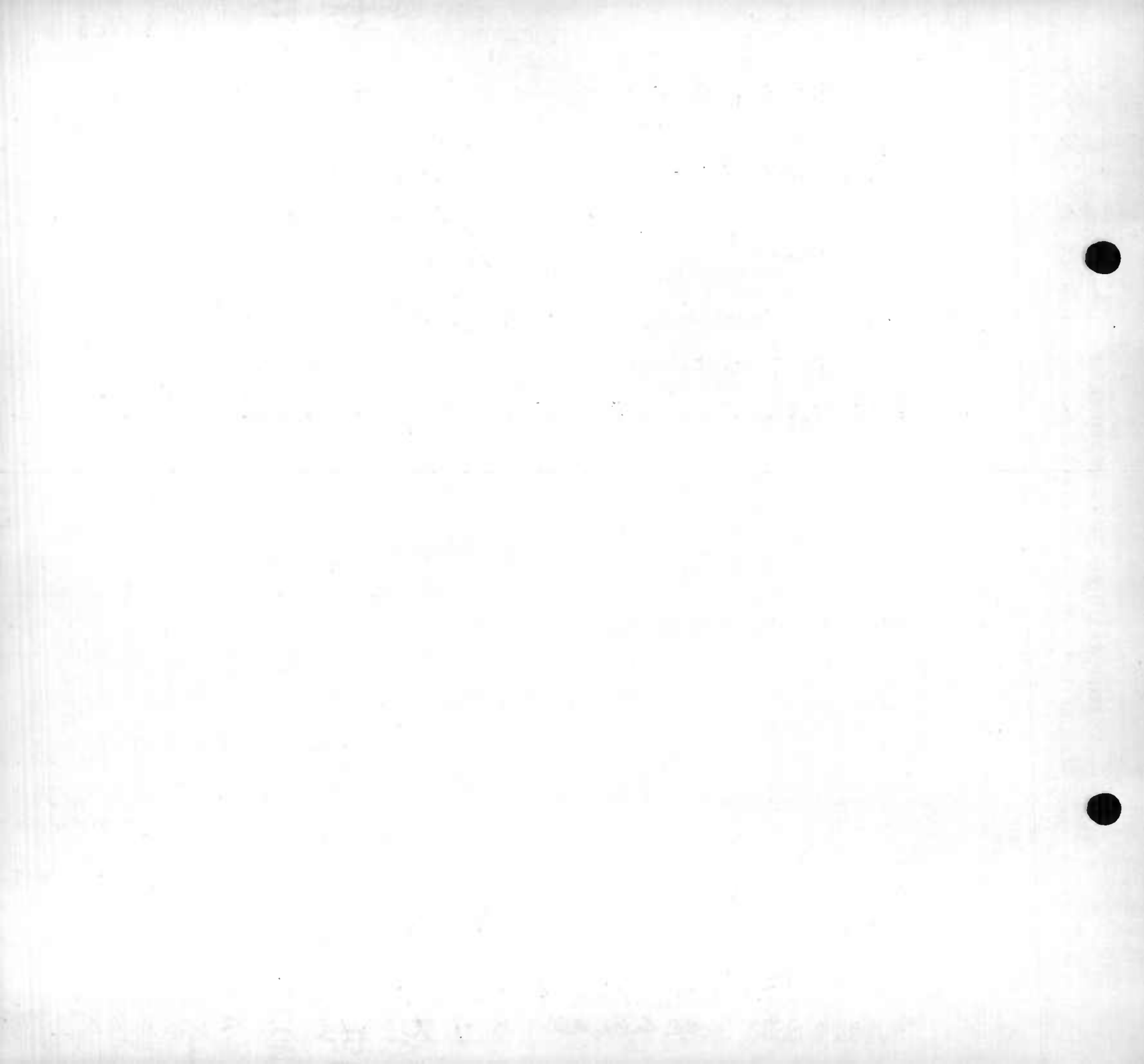
1912

1912

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

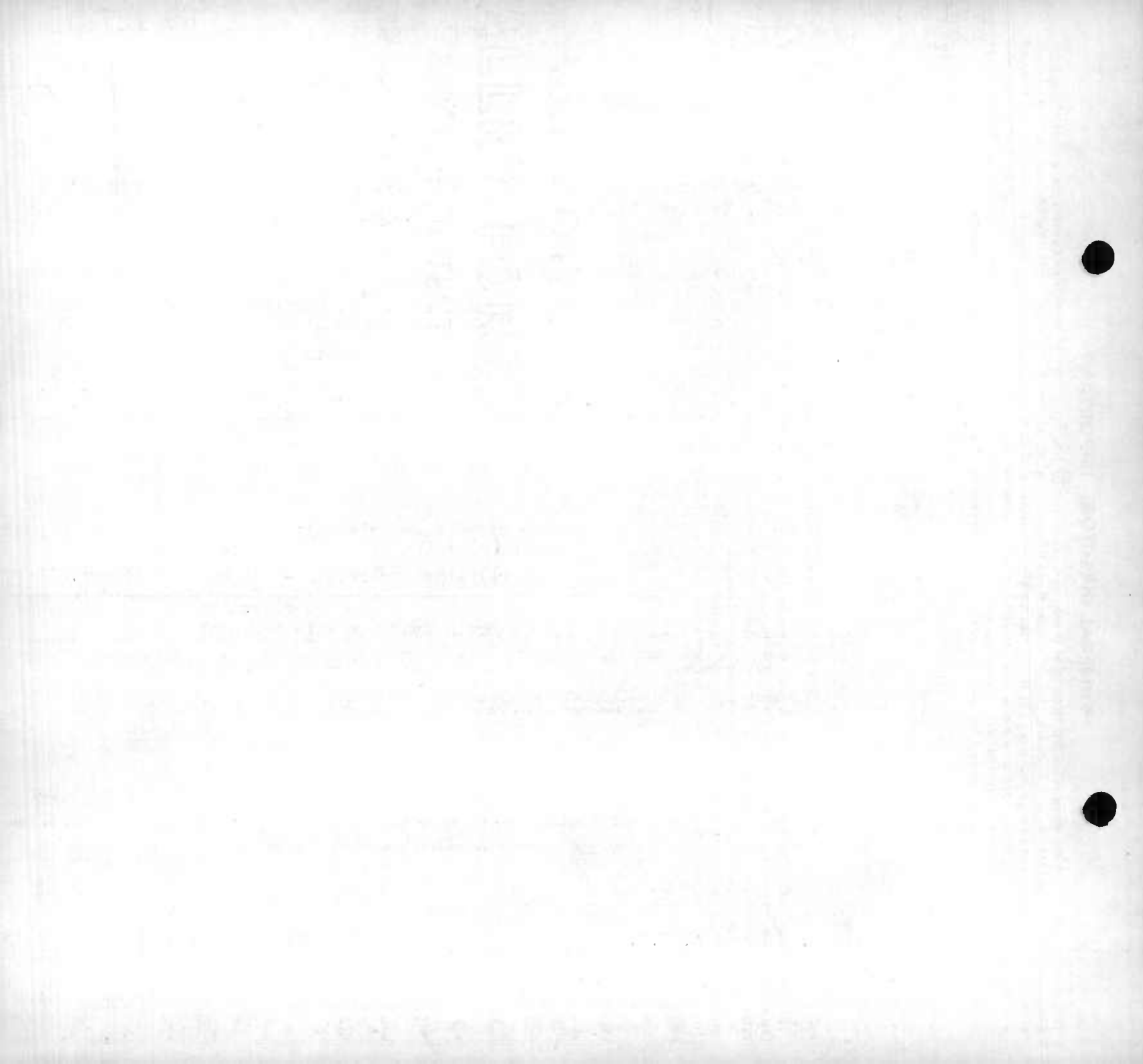
R 516 69 12724		BALTIMORE CITY HEALTH DEPARTMENT <b>CERTIFICATE OF DEATH</b>		REG. NO. 69 12724	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>William Ruffroe</i>		2. DATE AND HOUR OF DEATH <i>12-21-69 2:30 pm M.</i>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>md.</i> B. COUNTY		C. CITY OR TOWN <i>Baltimore</i>	
FULL NAME OF HOSPITAL OR INSTITUTION <i>Univ. of Md., Hosp.</i>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <i>M</i>		6. RACE <i>NEGRO</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <i>11-26-86</i>		9. AGE (In years lost birthday) <i>73</i>		10. If Under 1 Yr. Months Days II Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>GA.</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>MIKE RUFFROE</i>		14. MOTHER'S MAIDEN NAME <i>unR</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>YES WW II</i>		16. SOCIAL SECURITY NO. <i>280-030114</i>		17. INFORMANT <i>Ruby Ruffroe</i>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		19. CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Co. of the lung</i> (B) DUE TO, OR AS A CONSEQUENCE OF: (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>unknown</i>	
<p style="text-align: center;">II</p> <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</p>					
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>NO</i>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from <i>12/1/69</i> to <i>12/21/69</i> , that (I) (we) last saw the deceased alive on <i>12/21/69</i> and that (my) (our) opinion of death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <i>Ronica M. Kluge, M.D.</i>		23B. DATE SIGNED <i>12/21/69</i>		23C. PHYSICIAN'S NAME (Type) <i>RONICA M. KLUGE, M.D.</i>	
23D. ADDRESS <i>University Hospital Baltimore, Md.</i>		24A. BURIAL CREMATION, REMOVAL (Specify) <i>Buried</i>		24B. DATE <i>12/26/69</i>	
24C. NAME OF CEMETERY OR CREMATORY <i>Bethel National Bk. Bur.</i>		24D. LOCATION (City, town, or county) (State)		25A. DATE REC'D BY HEALTH DEPT. <i>DEC 26 1969</i>	
25B. NAME OF REGISTRAR <i>Robert E. Taylor</i>		25C. FUNERAL DIRECTOR <i>Wm. D. Blatney</i>		25D. ADDRESS <i>1701 M<sup>rs</sup> Cullis</i>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

D 435 69 12725		BALTIMORE CITY HEALTH DEPARTMENT <b>CERTIFICATE OF DEATH</b>		REG. NO. 69 12725	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>Helen Dalton</b>		2. DATE AND HOUR OF DEATH <b>December 22, 1969 7:30 A.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Harford</b>		C. CITY OR TOWN <b>Belair</b>	
FULL NAME OF HOSPITAL OR INSTITUTION <b>19 The Seton Psychiatric Institute 6400 Wabash Avenue Baltimore, Maryland 21215</b>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <b>Female</b>		6. RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <b>2-10-1898</b>		9. AGE (In years lost birthday) <b>71</b>		If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>home</b>		11. BIRTHPLACE (State or foreign country) <b>Baldwin, Baltimore Co., Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>United States</b>		13. FATHER'S NAME <b>Martin J. Lynch</b>		14. MOTHER'S MAIDEN NAME <b>Mary Shannahan</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>215-03-3249</b>		17. INFORMANT <b>Rev. Wm. L. Dalton, 6405 Orchard Road, Linthicum, Md.</b>	
18. <b>410.9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <b>Myocardial Infarction</b>		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>24 hours</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last, <b>Coronary atherosclerosis</b>		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Coronary atherosclerosis</b>		about 10 years	
		(B) DUE TO, OR AS A CONSEQUENCE OF: <b>mellitus</b>			
		(C) <b>General atherosclerosis - Diabetes</b>		16 yrs.-11 yrs	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>arteriosclerosis</b>		<b>Chronic Brain Syndrome with cerebral</b>			
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from <b>May 16, 1958</b> to <b>December 22, 1969</b> , that (I) (we) last saw the deceased alive on <b>December 22, 1969</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <b>Walter O. Jahrreiss M.D.</b>		23B. DATE SIGNED <b>Dec. 22, 1969</b>		23C. PHYSICIAN'S NAME (Type) <b>Walter O. Jahrreiss, M.D.</b>	
23D. ADDRESS <b>6400 Wabash Avenue, Baltimore, Maryland 21215</b>		24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>Dec. 24, 1969</b>	
24C. NAME OF CEMETERY or CREMATORY <b>St. John's Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Long Green Balto. Md.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>DEC 26 1969</b>	
25B. NAME OF REGISTRAR <b>Robert E. Taylor M.D.</b>		25C. FUNERAL DIRECTOR <b>Edward H. Comas &amp; Son, Abingdon, Md.</b>		25D. ADDRESS	

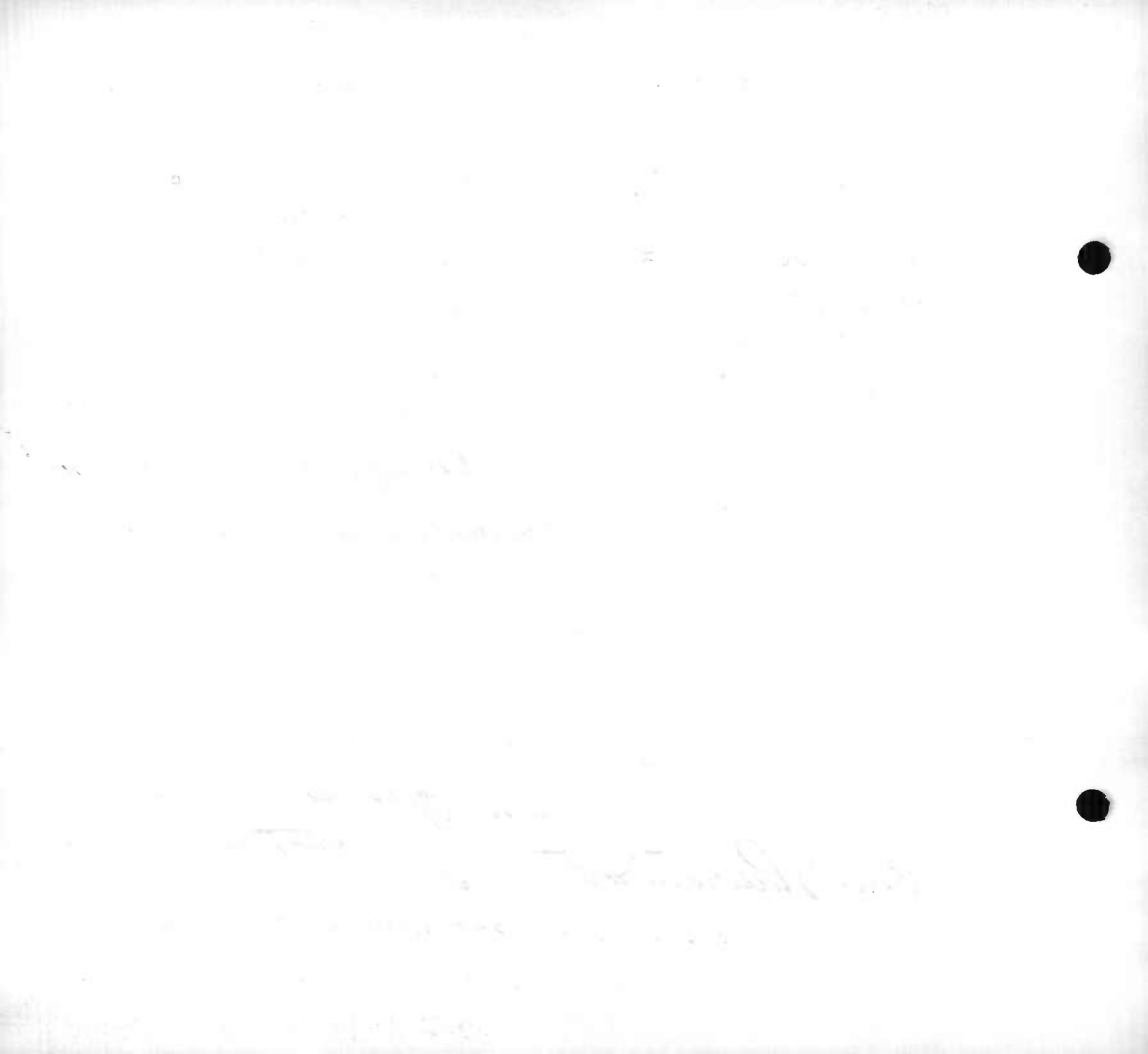




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<div style="display: flex; justify-content: space-between;"> <span>M460 69 12726</span> <span>BALTIMORE CITY HEALTH DEPARTMENT</span> </div> <h2 style="text-align: center;">CERTIFICATE OF DEATH</h2>		REG. NO. <b>69 12726</b>	
BIRTH NO. _____		2. DATE AND HOUR OF DEATH December 22nd, 1969 7.30 A.M.	
1. NAME OF DECEASED (Type or Print) <b>Miller, Veronica M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>Saint Agnes Hospital</b> <b>Caton &amp; Wilkens Aves.</b> <b>21229</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>82140.00</b> C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>101 Hazel Ave. 21227</b>	
5. SEX <b>Female</b>	6. RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7/10/1889</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife at home</b>		9. AGE (In years last birthday) <b>80</b>	
10B. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (State or foreign country) <b>Md.</b>	
13. FATHER'S NAME <b>John J. Lohig</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
14. MOTHER'S MAIDEN NAME <b>Elizabeth</b>			
15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>No</b>	
17. INFORMANT <b>Mrs Lillian M. Miller</b>		ADDRESS <b>Hazel Ave</b>	
18. <b>410.9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Coronary occlusion</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Anteriosclerotic heart disease</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>seconds</b> <b>years</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). _____			
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED _____	
20A. AUTOPSY? (Yes or No) <b>No</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? _____	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) _____			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) _____		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR? _____			
22. I certify that (I) (this hospital) attended the deceased from <b>9/26 1968</b> to <b>12-22 1969</b> that (I) (we) last saw the deceased alive on <b>11-26 1969</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. <b>Patient pronounced dead at St. Agnes Hospital.</b>			
23A. SIGNATURE <b>Cesar J. Pellerano</b>		23B. DATE SIGNED <b>12-22-69</b>	
23C. PHYSICIAN'S NAME (Type) <b>Cesar J. Pellerano MD</b>		23D. ADDRESS <b>2436 Washington Blvd. Baltimore Md. 21230</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12/24/69</b>	
24C. NAME OF CEMETERY OR CREMATORY <b>New Cathedral Cem.</b>		24D. LOCATION (City, town, or county) <b>Baltimore, Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JUL 26 1969</b>		25B. NAME OF REGISTRAR <b>John J. Pellerano</b>	
25C. FUNERAL DIRECTOR <b>John J. Pellerano</b>		ADDRESS <b>2436 Washington Blvd. Baltimore Md. 21230</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

H5-43 69 12727		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 69 12727	
BIRTH NO.		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Mrs. Minnie E. Hamilton	
2. DATE AND HOUR OF DEATH 12/22/69 11:28 P.M.		3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 48 Md. General Hospital		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) Apt. 431 4212 Lock Raven Blvd.	
5. SEX Female	6. RACE Caucasian	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH Nov. 5, 1906	9. AGE (In years last birthday) 67	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10B. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) South Carolina	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Hartwell Briggs		14. MOTHER'S MAIDEN NAME Emma Mims	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 220-44-9753		17. INFORMANT Mr. Clain E. Hamilton, Box 179 Manda Mill La. Phoenix, Maryland 21131	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. ASLVD		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) Subarachnoid hemorrhage 12 hrs.		INTERVAL BETWEEN ONSET AND DEATH Yrs.	
19A. DATE OF OPERATION D		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 12/22 1969 to 12/22 1969, that (I) (we) last saw the deceased alive on 12/22 1969 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE Louis E. Dunger		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 12/22/69	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS M.D.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12-26-1969		24C. NAME of CEMETERY or CREMATORY Washington Memorial Chapel	
24D. LOCATION Valley Forge, Pennsylvania		24E. DATE REC'D BY HEALTH DEPT. DEC 26 1969		24F. NAME OF REGISTRAR Robert E. Taylor, M.D.	
24G. FUNERAL DIRECTOR Wm. Cook-Brooks Towson, 1050 York Road Towson, Md. 21204		24H. ADDRESS			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>69 12728</u>	
BIRTH NO. <u>69 12728</u>		1. NAME OF DECEASED (Type or Print) <u>HEINRICH ERWIN V.</u>		2. DATE AND HOUR OF DEATH <u>12 mid night 23 Dec 1969</u> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <u>CH44</u>			(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		
			A. STATE <u>MD</u> B. COUNTY <u>BALTO. CO.</u> <u>5300</u>		
			C. CITY OR TOWN <u>BALTIMORE</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER <u>7912 35th St</u>		
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2/14/1910</u>	9. AGE (In years lost birthday) <u>59</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>unemployed Millwright</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Martin Company</u>		11. BIRTHPLACE (State or foreign country) <u>MD.</u>	
13. FATHER'S NAME <u>ADOLPH HEINRICH</u>			14. MOTHER'S MAIDEN NAME <u>ANNA SICHARD</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>Yes 6/1/32 to 8/31/34</u>			16. SOCIAL SECURITY NO. <u>212038530</u>		17. INFORMANT <u>Frieda C. Heinrich</u>
			ADDRESS <u>7912 E. 35th St.</u>		
18. <u>412.41</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.) <u>Pulm Oedema</u>			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Compensatory Cardiac Failure</u>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u>			(B) DUE TO, OR AS A CONSEQUENCE OF: <u>Chronic A.C.V.D.</u>		
			(C).....		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>12/17</u> 19 <u>69</u> to <u>12/22</u> 19 <u>69</u> that (I) (we) last saw the deceased alive on <u>12/22/69</u> 19 <u>69</u> and that (n) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Fisher</u>				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) <u>Fisher</u>				23D. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIED</u>		24B. DATE <u>12-26-69</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Baltimore National Cemetery</u>	
24D. LOCATION <u>Baltimore, Md.</u>		24E. LOCATION (City, town, or county) (State)			
25A. DATE REC'D BY HEALTH DEPT. <u>DEC 26 1969</u>		25B. NAME OF REGISTRAR <u>Robert E. Fisher</u>		25C. FUNERAL DIRECTOR <u>Philip E. Quach</u>	
				ADDRESS <u>1211 Chesapeake Ave.</u>	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 69 12729	
<b>520 69 12729</b> BIRTH NO.				<b>CERTIFICATE OF DEATH</b>	
1. NAME OF DECEASED (Type or Print) <u>Johns, Edward</u>			2. DATE AND HOUR OF DEATH <u>12-22-69</u>   <u>11:24 A.</u> M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Pleasant Manor Nursing and Convalescent Center.</u>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Md</u> B. COUNTY <u>2534</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>3549-6th St</u>		
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Apr. 2, 1889</u>		9. AGE (In years lost birthday) <u>82</u> <u>80</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret Policeman</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Western Md. Railroad</u>		11. BIRTHPLACE (State or foreign country) <u>New Jersey</u>	
13. FATHER'S NAME <u>Unknown</u>			14. MOTHER'S MAIDEN NAME <u>Unknown</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>Yes</u> <u>WW1</u>		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <u>Mrs. Sophie H. Johns 3549 6th Street 21225</u>	
18. <u>437.91</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>Nephrosclerosis</u>			CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>Uremia</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>Dehydration</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>Intermittent Cerebral Vascular Disease</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 months</u> <u>2 weeks</u> <u>years</u> <u>years</u>
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) ( <del>the</del> hospital) attended the deceased from <u>9/23/69</u> 19 to <u>12/22/69</u> 19, that (I) ( <del>we</del> ) last saw the deceased alive on <u>12-16</u> 19 <u>69</u> and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>we</del> ) ( <del>did not</del> ) view the body after death.					
23A. SIGNATURE <u>Frank G. Kuenn M.D.</u>				23B. DATE SIGNED <u>12-23-69</u>	
23C. PHYSICIAN'S NAME (Type) <u>FRANK G. KUENN, M.D.</u>				23D. ADDRESS <u>721 MEDICAL ARTS BLDG. BALTO MD</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Cremation</u>		24B. DATE <u>12/24/69</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Crematory</u>	
24D. LOCATION <u>Baltimore, Maryland</u>		25A. DATE REC'D BY HEALTH DEPT. <u>DEC 26 1969</u>			
25B. NAME OF REGISTRAR <u>Robert E. Tabor, M.D.</u>		25C. FUNERAL DIRECTOR ADDRESS <u>McKully Rd - 237 Patapsco Ave. 21225</u>			





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital, and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 69 12730	
<div style="display: flex; justify-content: space-between;"> <span>B653 69 12730</span> <span><b>CERTIFICATE OF DEATH</b></span> </div>					
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>John H. Brandt Sr.</i>		2. DATE AND HOUR OF DEATH <i>12-20-69 9:27 PM</i> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <i>Johns Hopkins Hospital</i>			A. STATE <i>Baltimore City, Maryland.</i> B. COUNTY <i>603</i>		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			C. CITY OR TOWN <i>Baltimore</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER <i>26 No. Patterson Park Ave</i>		
5. SEX <i>Male</i>	6. RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <i>6-7-1893</i>		9. AGE (In years lost birthday) <i>76</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>night watchman</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Baltimore</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
13. FATHER'S NAME <i>William Brandt</i>			14. MOTHER'S MAIDEN NAME <i>Unknown</i>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Mrs. Frieda E. Eisner</i>	
				ADDRESS <i>5523 The Alameda Blvd 2122</i>	
18. <i>206.9 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE <i>Intracerebral Hemorrhage approx 30 min</i> DUE TO, OR AS A CONSEQUENCE OF: (B) <i>Monocytic Leukemia</i> DUE TO, OR AS A CONSEQUENCE OF: (C) _____		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <i>GI Bleeding</i>					
19A. DATE OF OPERATION <i>11-26-69</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Intestinal Obstruction</i>		20A. AUTOPSY? (Yes or No) <i>Yes</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <i>No</i>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <i>None</i>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>11-12-69</i> 19 <i>69</i> to <i>12-21</i> 19 <i>69</i> , that (I) (we) last saw the deceased alive on <i>12-21</i> 19 <i>69</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) ( <u>We</u> ) ( <u>did</u> ) ( <u>did not</u> ) view the body after death.					
23A. SIGNATURE <i>David M. Capuzzi M.D.</i> OEGREE				23B. DATE SIGNED <i>12-21-69</i>	
23C. PHYSICIAN'S NAME (Type) <i>David M. Capuzzi M.D.</i> OEGREE				23D. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>12/23/69</i>		24C. NAME OF CEMETERY or CREMATORY <i>Holy Cross</i>	
24D. LOCATION <i>Ritchie Highway A. A. Co. Md.</i>		24E. FUNERAL DIRECTOR <i>McGee/H/237 Patapsco Ave. 21225</i>			
25A. DATE REC'D BY HEALTH DEPT. <i>DEC 26 1969</i>		25B. NAME OF REGISTRAR <i>Robert E. Taylor, Jr.</i>		25C. FUNERAL DIRECTOR ADDRESS	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

C434 69 12731				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 69 12731	
BIRTH NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>MARY FRANCES CALDWELL</b>				2. DATE AND HOUR OF DEATH <b>12/20/69</b> <b>125</b> P. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>906</b>			
FULL NAME OF HOSPITAL OR INSTITUTION <b>44 UNION MEMORIAL HOSPITAL</b>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <b>BALTIMORE</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <b>2926 HARFORD ROAD.</b>			
5. SEX <b>F</b>	6. RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>6/18/88</b>	9. AGE (In years last birthday) <b>81</b>	If Under 1 Yr. Months: Days:	If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>GEORGE I KING</b>				14. MOTHER'S MAIDEN NAME <b>SARAH DULANEY</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>216-28-7802</b>		17. INFORMANT <b>Mr. GEORGE CALDWELL</b>		ADDRESS <b>2921 Alameda Lane</b>	
18. <b>4 27.2</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>RESPIRATORY FAILURE</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>CARDIAC ARREST</b>				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>RESPIRATORY FAILURE</b> (B) DUE TO, OR AS A CONSEQUENCE OF: <b>CARDIAC ARREST</b> (C) _____			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) <u>(this hospital)</u> attended the deceased from <u>11/27</u> 19 <u>69</u> to <u>12/20</u> 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>12/20</u> 19 <u>69</u> and that in <u>(my)</u> (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Anne L. Leddy M.D.</b>				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>12/20/69</b>	
23C. PHYSICIAN'S NAME (Type) <b>Union Memorial Hospital</b>				23D. ADDRESS <b>Union Memorial Hospital</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>12-23-69</b>		24C. NAME of CEMETERY or CREMATORY <b>WOODLAWN CEMETERY</b>		24D. LOCATION (City, town, or county) (State) <b>BALTO., Md</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 26 1969</b>		25B. NAME OF REGISTRAR <b>Robert E. Gable, M.D.</b>		25C. FUNERAL DIRECTOR <b>J. Walter Conklin</b>		ADDRESS <b>3444 BELAIR Rd</b>	

General Account  
Respectfully  
Submitted

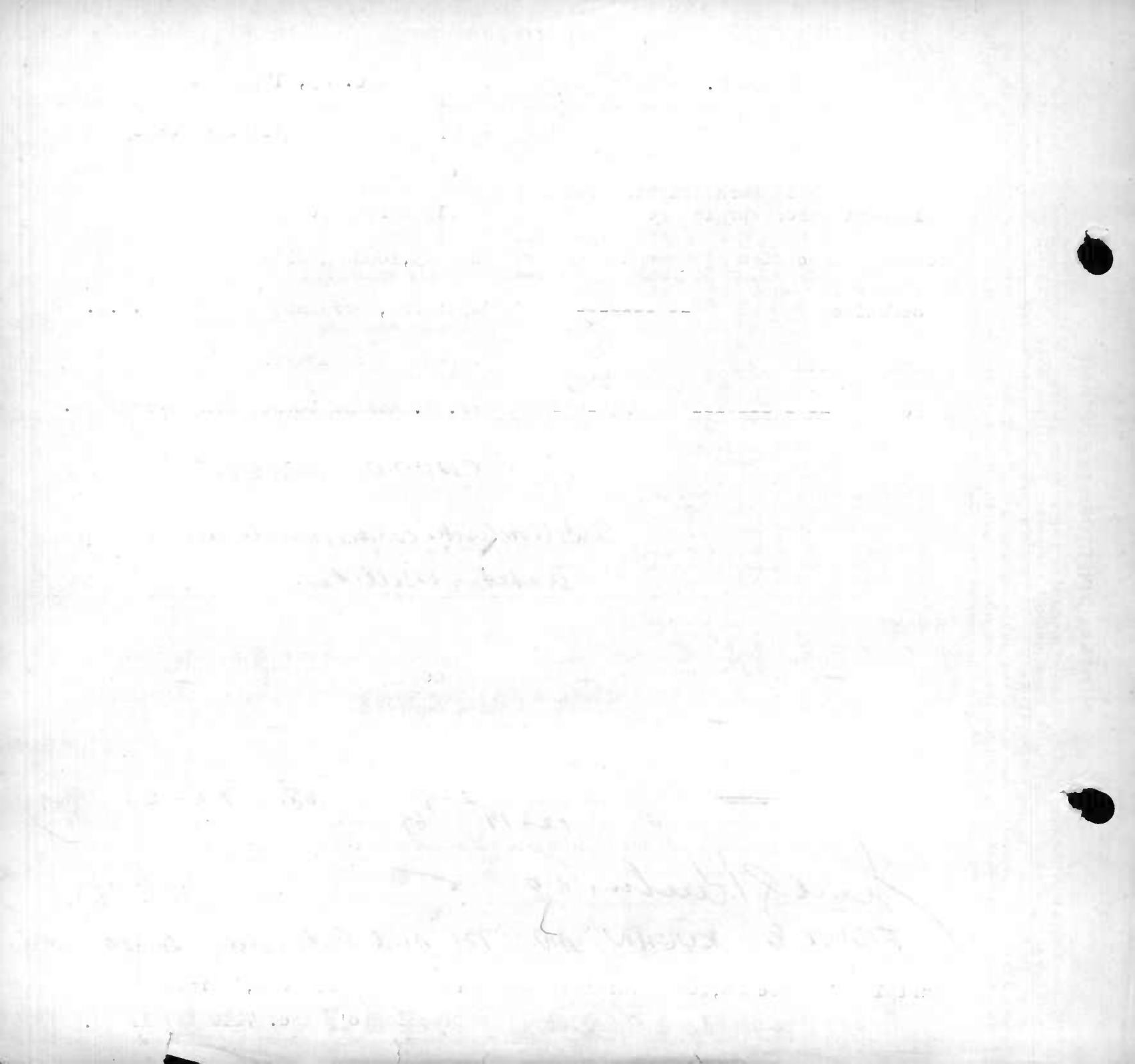
No

Attest 12th day of March 1891  
J. H. [illegible]

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
CERTIFICATE OF DEATH									
BIRTH NO. <span style="float: right;">M460 69 12732</span>					REG. NO. <span style="float: right;">69 12732</span>				
1. NAME OF DECEASED (Type or Print) <b>CLARAM. MILLER</b>					2. DATE AND HOUR OF DEATH <b>Dec. 23, 1969</b>				
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION <b>90 4615 Park Heights Avenue Pleasant Manor Nursing Home</b>					A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore County</b> <span style="float: right;">5300</span>				
					C. CITY OR TOWN <b>Rosedale</b>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
					E. STREET AND NUMBER <b>6713 Garvey Road</b>				
5. SEX <b>female</b>	6. RACE <b>Caucasian</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>June 23, 1888</b>	9. AGE (In years last birthday) <b>81</b>	11. Under 1 Yr. Months: Days: Hours: Min.		12. Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			10B. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Adam Huth</b>					14. MOTHER'S MAIDEN NAME <b>Jennie Engelmeyer</b>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>			16. SOCIAL SECURITY NO. <b>214-03-3501D</b>		17. INFORMANT <b>Mrs. M. Evelyn Mooney 6713 Garvey Rd.</b>				
18. CAUSE OF DEATH					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphemia, etc. It means the disease, injury or complication which caused death.) <b>250.9 I</b>					<b>3 min.</b>				
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>CARDIAC ARREST</b>				
					(B) Anteroinfarctive coronary atherosclerosis DUE TO, OR AS A CONSEQUENCE OF:				
					(C) Diabetes Mellitus				
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).									
19A. DATE OF OPERATION <b>0</b>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED -----		20A. AUTOPSY? (Yes or No) <b>no</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? -----		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) -----			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) -----		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) -----				
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) -----			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? -----				
22. I certify that (I) (this <del>hospital</del> ) attended the deceased from <b>2-9 1968</b> to <b>12-23 1969</b> , that (I) (we) lost saw the deceased alive on <b>12-19 1969</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <b>Frank G. Kuehn MD</b>					23B. DATE SIGNED <b>12/23/69</b>			23C. PHYSICIAN'S NAME (Type) <b>FRANK G. KUEHN MD</b>	
23D. ADDRESS <b>721 Med Arts Bldg Balto 1 Md</b>									
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>Dec 26, 69</b>		24C. NAME of CEMETERY or CREMATORY <b>Parkwood Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 26 1969</b>			25B. NAME OF REGISTRAR <b>Robert E. Jaber, MD</b>			25C. FUNERAL DIRECTOR <b>Druppel Bro's Inc. 7110 Belair Rd. 21206</b>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

69 12733		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 69 12733	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Lola M. Gilliam		December 20, 1969   4:30 AM M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			A. STATE B. COUNTY		
The Johns Hopkins Hospital Baltimore, Maryland, 21205			MARYLAND BALTIMORE CITY 909		
			C. CITY OR TOWN		D. INSIDE CITY LIMITS?
			BALTIMORE		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER		
			1301 N. CENTRAL AVENUE		
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH	9. AGE (In years lost birthday)	If Under 1 Yr. Months: Days: Hours: Min.
FEMALE	NEGRO	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	5-18-23	46	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
			MC		
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
Walter Outlaw			Leanne Outlaw		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT		ADDRESS
			Ella Outlaw 1227		7 Central Ave
18. 5-771-01-818.9 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			CAUSE OF DEATH		
(This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.)			(A) IMMEDIATE CAUSE Hepatic coma		
ANTECEDENT CAUSES			DUE TO, OR AS A CONSEQUENCE OF:		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) Laennec's hepatic cirrhosis		
			DUE TO, OR AS A CONSEQUENCE OF:		
			(C) Disseminated Tuberculosis with malabsorption		
			20 years		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			History of syphilis, treated		
19A. DATE OF OPERATION			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
2 XXXX			XXXX	yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
no		XXXX		XXX	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(Month) (Day) (Year) (Hour)		While At Work <input checked="" type="checkbox"/> Not While At Work <input type="checkbox"/>		XX	
XXXX					
22. I certify that (1) (this hospital) attended the deceased from December 1, 19 69 to December 20, 19 69, that (1) (we) last saw the deceased alive on December 20, 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
George H. Sack, Jr. M.D.				12/20/69	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
George H. Sack, Jr., M.D.				601 N. Broadway, Baltimore, Md., 21205	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE	24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)
Removal		12/24/69	Windsor		North Carolina
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
DEC 26 1969		Robert E. Taylor, Jr.		108 W. 3rd St. Montgomery, AL	





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO.	
69 12734		69 12734		69 12734	
1. NAME OF DECEASED (Type or Print) <b>HAZEL BROWN</b>		2. DATE AND HOUR OF DEATH <b>12/27/69</b> <b>655pm</b> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>UNION MEMORIAL HOSPITAL</b>		4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE <b>me.</b> B. COUNTY <b>1304</b>			
5. SEX <b>F</b>		6. RACE <b>NEURO</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <b>7/31/11</b>		9. AGE (In years last birthday) <b>58</b>		If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>-</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>AMERICA</b>		13. FATHER'S NAME <b>ELIJAH STEWART</b>		14. MOTHER'S MAIDEN NAME <b>MARY ETTA BOND</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>212-122-180</b>		17. INFORMANT <b>J. Roger Brown</b>	
18. <b>403 X 1</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Chronic Renal Failure</b>		CAUSE OF DEATH (A) IMMEDIATE CAUSE <b>Chronic Renal Failure</b> DUE TO, OR AS A CONSEQUENCE OF: (B) <b>Hypertensive nephropathy</b> DUE TO, OR AS A CONSEQUENCE OF: (C) <b>essential hypertension (probable)</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>5 years</b> <b>10 years</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from <b>12/27</b> 19 <b>69</b> to <b>12/27</b> 19 <b>69</b> , that (1) (we) last saw the deceased alive on <b>12/27</b> 19 <b>69</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Anne L. Liddy</b> M.D.		23B. DATE SIGNED <b>12/27/69</b>		23C. PHYSICIAN'S NAME (Type) <b>DR ANNE LEDDY</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1/2/70</b>		24C. NAME OF CEMETERY or CREMATORY <b>Arbiter Mem. Pk.</b>	
24D. LOCATION (City, town, or county) (State) <b>Balto. Md.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>DEC 26 1969</b>		25B. NAME OF REGISTRAR <b>Robert E. [unclear]</b>	
25C. FUNERAL DIRECTOR <b>Wm. J. Chaturman</b>		25D. ADDRESS <b>Dr-1701 W. Culloch St. Baltimore</b>		25E. ADDRESS <b>Dr-1701 W. Culloch St. Baltimore</b>	

1/20/2000 10:00 AM

10:00 AM

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

69 12735

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO. 69 12735

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>F. George M. Lankford, Sr.</b>		2. DATE AND HOUR OF DEATH <b>Monday Dec. 22, 69</b>		M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>2841</b>			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>House in the pines Belvedere</b>				C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <b>Male</b>				6. RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Collector for Hecht Co. Hecht Co.</b>		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH <b>March 7, 1886</b>		9. AGE (In years last birthday) <b>83</b>	
11. BIRTHPLACE (State or foreign country) <b>Virginia</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Samuel Lankford</b>				14. MOTHER'S MAIDEN NAME <b>Susan ?</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>216-01-5292A</b>		17. INFORMANT <b>Daughter-in-law</b> <b>Anna M. Hayworth</b> ADDRESS <b>3710 Ferndale Ave. 21207</b>			
18. <b>433.9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH <b>Cerebro-vascular thrombosis</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>	
				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Cerebral arteriosclerosis</b>		<b>10 years</b>	
				(B) DUE TO, OR AS A CONSEQUENCE OF:			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <b>Jan. 16, 1961</b> to <b>Dec. 22, 1969</b> . that (I) ( <del>we</del> ) last saw the deceased alive on <b>Dec. 12, 1969</b> and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>we</del> ) ( <del>did</del> ) (did not) view the body after death.							
23A. SIGNATURE <b>Marvin Goldstein</b>				23B. DATE SIGNED <b>12/22/69</b>			
23C. PHYSICIAN'S NAME (Type) <b>MARVIN GOLDSTEIN M.D.</b>				23D. ADDRESS <b>6001 PARK HEIGHTS AVE. BALTO. MD.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>Dec 23, 69</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cem.</b>		24D. LOCATION (City, town, or county) (State) <b>Frederick Rd. Baltimore Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 26 1969</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor, M.D.</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Loring Byers 8728 Liberty Rd. Randallstown</b>			

12/31/69 - Correction form from funeral director.

LBC.

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO.	
69 12736		69 12736		69 12736	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
ZAISSER, DORIS C.		DECEMBER 22, 1969		12:45 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 40 ST. AGNES HOSPITAL		A. STATE MARYLAND		B. COUNTY	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER 4504 DUNLAND RD UPLANDS APT C 21229			
5. SEX FEMALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 02/08/07	9. AGE (In years last birthday) 62	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED SECRETARY		10B. KIND OF BUSINESS OR INDUSTRY SUMMERS FERTILIZERS		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME WILLIAM ZAISSER		14. MOTHER'S MAIDEN NAME BERTHA (NEE FOOS) ZAISSER	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NONE		16. SOCIAL SECURITY NO. 212-03-1411		17. INFORMANT ST. AGNES HOSPITAL RECORDS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, pneumonia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Coronary &amp; Pericardial (200%) General Malnutrition</i> (B) DUE TO, OR AS A CONSEQUENCE OF: (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 years	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from DECEMBER 21, 1969 to DECEMBER 22, 1969 that (I) (we) lost saw the deceased alive on DECEMBER 22, 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. <i>My assistant</i>					
23A. SIGNATURE <i>Eliot W. Schuman M.D.</i>		23B. DATE SIGNED			
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS BALTIMORE, MD 21229 ST. AGNES HOSP; CATON & WILKENS AVES.			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE Dec. 24, 1969		24C. NAME OF CEMETERY or CREMATORY Loudon Park Cem.	
24D. LOCATION (City, town, or county) (State) Balto. Md.		25A. DATE REC'D BY HEALTH DEPT. DEC 26 1969		25B. NAME OF REGISTRAR <i>Robert E. Taber, R.D.</i>	
25C. FUNERAL DIRECTOR G. Truman Schwab		25D. ADDRESS 5151 Balto. National Pike		25E. ADDRESS 21229	

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 69 12737	
BIRTH NO. 69 12737		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Print) BUSSARD, HELEN EMMA Bussard		2. DATE AND HOUR OF DEATH DECEMBER 22, 1969 6:00 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION ST AGNES HOSPITAL		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY Balto. Co. 53.00 C. CITY OR TOWN ELKBRIDGE D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER HUNT CLUB ROAD			
5. SEX FEMALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 29, 1906	9. AGE (In years last birthday) 63	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cashier		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND Balto.	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME GEORGE GALLOWARY DEC'D		14. MOTHER'S MAIDEN NAME Annie R. Gohan	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 217-16-3317		17. INFORMANT RECORD'S BALTIMORE MD 21229 ST AGNES HOSPITAL WILKENS & CATON AVE	
18. CAUSE OF DEATH I 250.9 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (A) IMMEDIATE CAUSE cvA DUE TO, OR AS A CONSEQUENCE OF: (B) Diabetes, Cerebral, Kidney disease DUE TO, OR AS A CONSEQUENCE OF: (C) II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (X) (this hospital) attended the deceased from DECEMBER 21, 1969 to DECEMBER 22, 1969 that (X) (we) last saw the deceased alive on DECEMBER 22, 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (not) view the body after death.					
23A. SIGNATURE CHING-HUI TSAI, M.D.		23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type) CHING-HUI TSAI, H.D.	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE Dec. 24, 1969		24C. NAME of CEMETERY or CREMATORY Lakeview Cem.	
24D. LOCATION Carroll, Md.		24E. NAME of REGISTRAR Robert E. Gahan, M.D.		24F. FUNERAL DIRECTOR G. Truman Schwab	
24G. ADDRESS 3512 Frederick Ave., Balto. Md.		24H. DATE REC'D BY HEALTH DEPT. DEC 26 1969			

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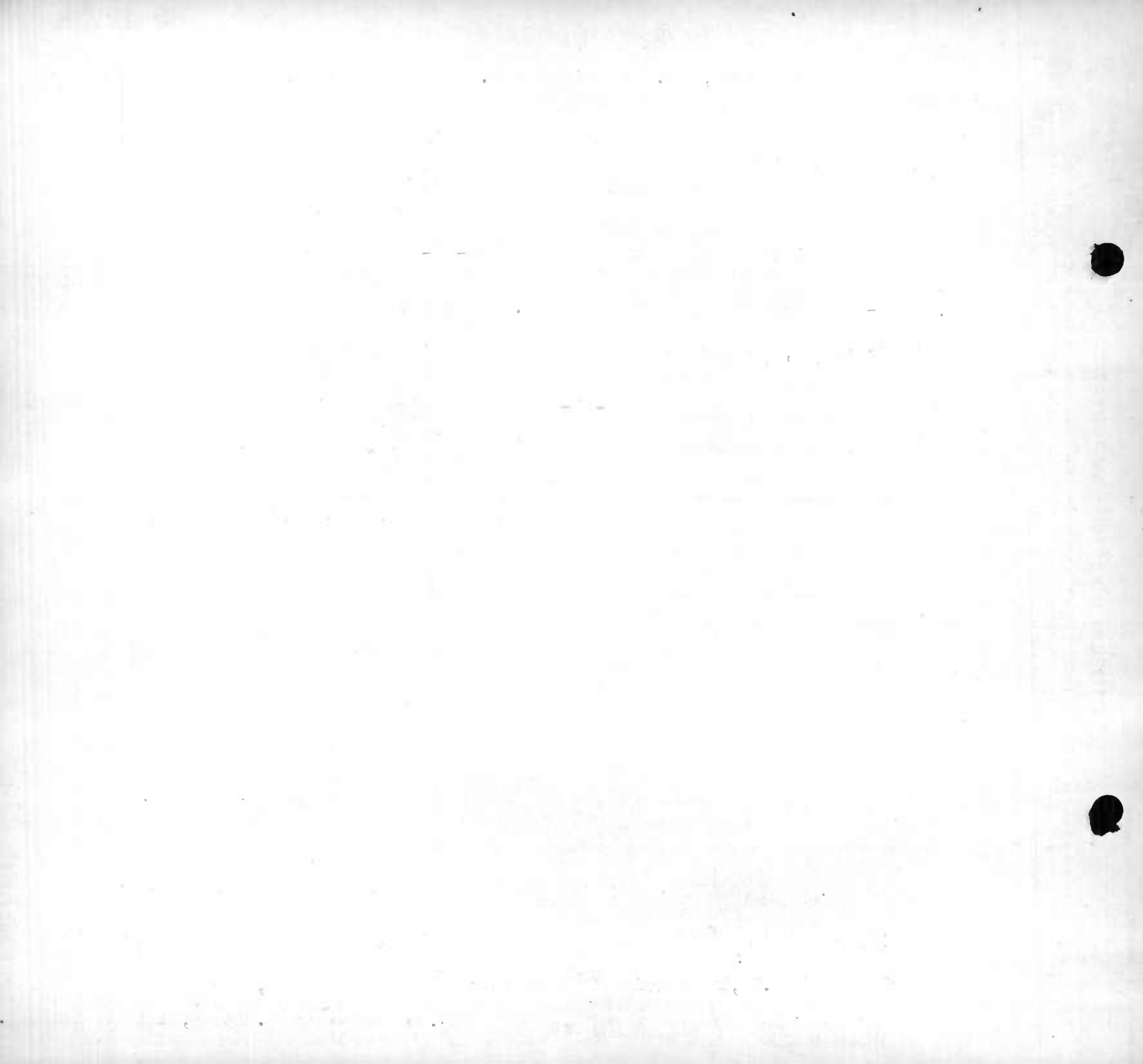
141. 142. 143. 144. 145. 146. 147. 148. 149. 150.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="font-size: 1.2em;">69 12738</span>
BIRTH NO. <span style="font-size: 1.5em;">69 12738</span>		<b>CERTIFICATE OF DEATH</b>		
1. NAME OF DECEASED (Type or Print) <span style="font-size: 1.2em;">Schaeffer, Mr. Millington A.</span>		2. DATE AND HOUR OF DEATH <span style="font-size: 1.2em;">12/23/69</span> <span style="font-size: 1.2em;">9:20 A.M.</span>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION <span style="font-size: 1.5em;">91</span> (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <span style="font-size: 1.2em;">Keswick</span> <span style="font-size: 1.2em;">700 West 40th Street</span>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <span style="font-size: 1.2em;">Maryland</span> B. COUNTY <span style="font-size: 1.5em;">1307</span> C. CITY OR TOWN <span style="font-size: 1.2em;">Baltimore</span> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <span style="font-size: 1.2em;">700 West 40th Street</span>		
5. SEX <span style="font-size: 1.2em;">M</span>	6. RACE <span style="font-size: 1.2em;">White</span>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <span style="font-size: 1.2em;">6-14-92</span>	9. AGE (In years lost birthday) <span style="font-size: 1.2em;">77</span>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">Foreman-Tool Room</span>		10B. KIND OF BUSINESS OR INDUSTRY <span style="font-size: 1.2em;">Consolidated Eng.</span>		11. BIRTHPLACE (State or foreign country) <span style="font-size: 1.2em;">Maryland</span>
12. CITIZEN OF WHAT COUNTRY? <span style="font-size: 1.2em;">USA</span>		13. FATHER'S NAME <span style="font-size: 1.2em;">Millington A. Schaeffer</span>		
14. MOTHER'S MAIDEN NAME <span style="font-size: 1.2em;">Minnie Horn</span>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, na or unknown) (If yes, give war or dates of service) <span style="font-size: 1.2em;">no</span>		
16. SOCIAL SECURITY NO. <span style="font-size: 1.2em;">213-01-0472</span>		17. INFORMANT ADDRESS <span style="font-size: 1.2em;">Keswick Medical Records 700 West 40th</span>		
18. <span style="font-size: 1.5em;">492X1</span> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH <span style="font-size: 1.5em;">Pulmonary edema, acute</span> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <span style="font-size: 1.5em;">Emphysema, with cor pulmonale</span> (B) DUE TO, OR AS A CONSEQUENCE OF: (C).....		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <span style="font-size: 1.2em;">5 hours</span> <span style="font-size: 1.2em;">10 years</span>
MEDICAL CERTIFICATION				
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION <span style="font-size: 1.2em;">0</span>	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (attify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		
22. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <span style="font-size: 1.2em;">May 2</span> 19 <span style="font-size: 1.2em;">68</span> to <span style="font-size: 1.2em;">Dec. 23</span> 19 <span style="font-size: 1.2em;">69</span> , that (I) ( <del>we</del> ) last saw the deceased alive on <span style="font-size: 1.2em;">12/23/69</span> 19 and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>we</del> ) (did) (did not) view the body after death.				
23A. SIGNATURE <span style="font-size: 1.5em;">W.B. Daniels, Jr.</span> <span style="font-size: 1.2em;">M.D.</span>		23B. DATE SIGNED <span style="font-size: 1.2em;">12/23/69</span>		23C. PHYSICIAN'S NAME (Type) <span style="font-size: 1.2em;">W.B. DANIELS, Jr.</span>
23D. ADDRESS <span style="font-size: 1.2em;">Keswick, Baltimore, Md., 21211</span>		24A. BURIAL CREMATION, REMOVAL (Specify) <span style="font-size: 1.2em;">Burial</span>		
24B. DATE <span style="font-size: 1.2em;">Dec. 27, 1969</span>	24C. NAME OF CEMETERY or CREMATORY <span style="font-size: 1.2em;">Druid Ridge Cemetery</span>	24D. LOCATION (City, town, or county) (State) <span style="font-size: 1.2em;">Baltimore, Maryland</span>		
25A. DATE REC'D BY HEALTH DEPT. <span style="font-size: 1.2em;">DEC 26 1969</span>	25B. NAME OF REGISTRAR <span style="font-size: 1.2em;">J. E. Fisher, M.D.</span>	25C. FUNERAL DIRECTOR <span style="font-size: 1.2em;">Howard County Fun. Home of Harry H. Witzke, Ellicott City, Md.</span>		



K-525

1

BALTIMORE CITY HEALTH DEPARTMENT

69 12739

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

69 12739

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>HARRY L. KNICKMAN</b>		2. DATE OF DEATH Known <input type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour <b>12 26 69 8:20 a.m.</b>	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>St. Agnes Hospital D.O.A.</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>December 26, 1969 8:20 a.m.</b>	
6. SEX <b>Male</b>		7. RACE <b>White</b>	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Balto.</b>	
9. DATE OF BIRTH <b>3/24/1915</b>		10. AGE (In years lost birthday) <b>54</b>	
11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		14B. KIND OF BUSINESS OR INDUSTRY <b>Proctor-Gamble</b>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>yes WW II</b>		17. SOCIAL SECURITY NO. <b>215-05-6537</b>	
18. INFORMANT <b>Mrs. Harry L. Knickman, 1409 Forest Pk Ave.</b>		ADDRESS <b>21207</b>	
19. CAUSE OF DEATH <b>412.4</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		(A) IMMEDIATE CAUSE <b>Arteriosclerotic cardiovascular disease</b> DUE TO, OR AS A CONSEQUENCE OF: (B) _____ (C) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION <b>2</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?		21. AUTOPSY? (Yes or No) <b>YES</b>	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <b>Ronald N. Kornblum</b> M.D. EXAMINER'S NAME (Type) <b>Ronald N. Kornblum, M.D.</b> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>12/27/69</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12/30/69</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Baltimore National Cem</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 26 1969</b>		25B. NAME OF REGISTRAR <b>P. E. Fisher, M.D.</b>	
25C. FUNERAL DIRECTOR <b>Witzke, Inc.</b>		ADDRESS <b>1630 Edmondson Ave. Catonsville</b>	

ACADEMIC RECORD

THE CHURCH

THE CHURCH

THE CHURCH

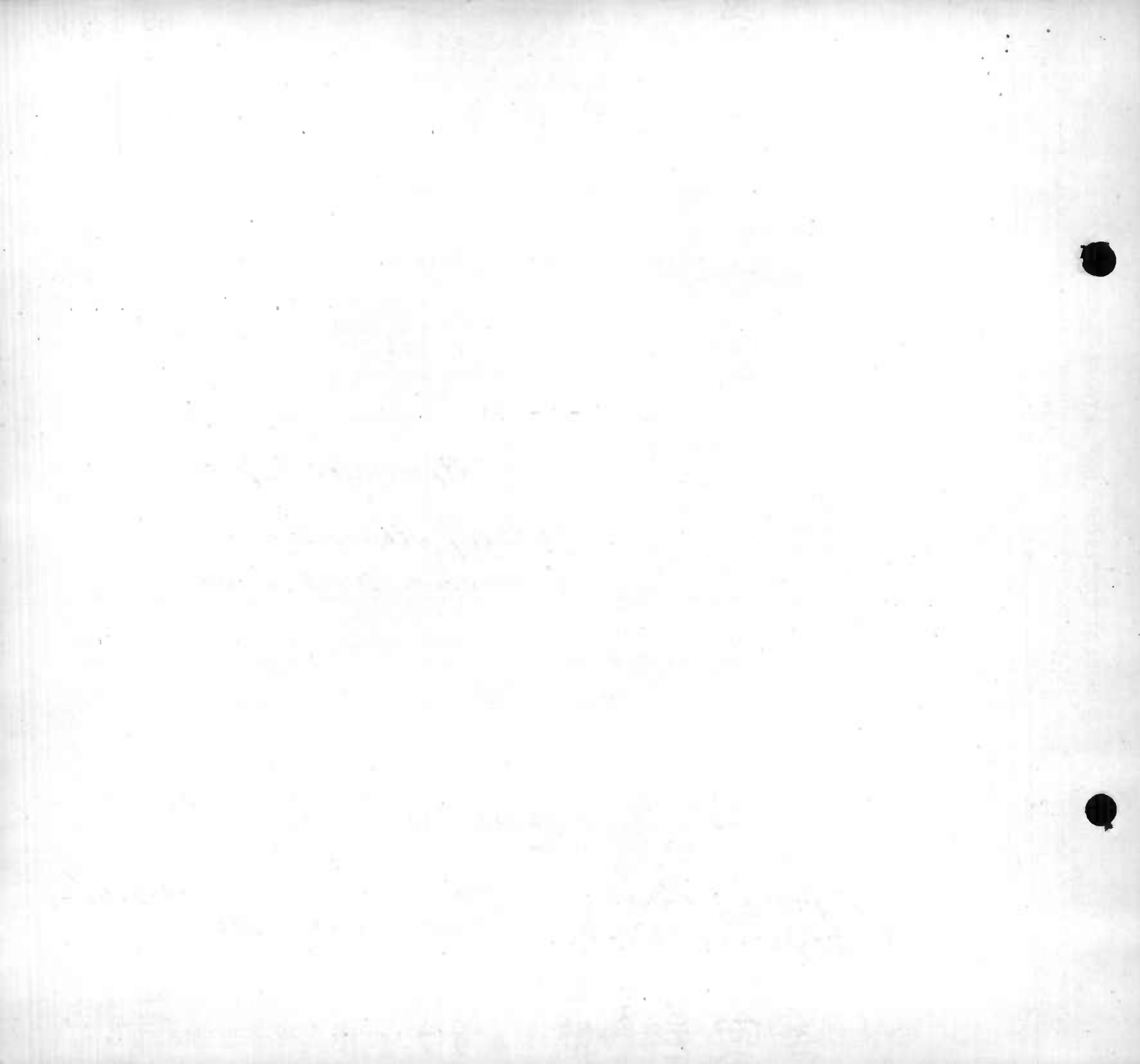
THE CHURCH

THE CHURCH

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="font-size: 2em;">X</span>	
69 12740		69 12740		69 12740	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Miss Mary Theresa Brennan		12-23-69 11:50 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION  91 Jenkins Memorial Hospital			A. STATE Md. B. COUNTY Balt. 5300		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER 114 Westowne Road.		
5. SEX F	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 1, 1887	9. AGE (In years last birthday) 82	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Lonaconing, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Edward Brennan			14. MOTHER'S MAIDEN NAME Ann Durkin		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 220-44-6251	17. INFORMANT Sr. Rose Jenkins Memorial Hosp		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)  410.9 I ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE Myocardial Infarction minutes DUE TO, OR AS A CONSEQUENCE OF: (B) Coronary atherosclerosis years DUE TO, OR AS A CONSEQUENCE OF: (C) Arteriosclerotic Heart Disease years		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (H) (this hospital) attended the deceased from Jan 3 1966 to Dec 23 1969, that (I) (we) last saw the deceased alive on 12/23 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE J. Raymond Gladue			23B. DATE SIGNED 12/24/69		Attending Phys. <input checked="" type="checkbox"/> Med. Director <input checked="" type="checkbox"/> Staff Phys. <input type="checkbox"/>
23C. PHYSICIAN'S NAME (Type) J. Raymond Gladue			23D. ADDRESS 1000 Caton Ave.		
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/27/69		24C. NAME OF CEMETERY or CREMATORY St. Michaels	
24D. LOCATION Frostburg, Maryland		24E. FUNERAL DIRECTOR Witzke, Inc., 1630 Edmondson Ave.,		24F. ADDRESS Catonsville	
25A. DATE REC'D BY HEALTH DEPT. DEC 26 1969		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Witzke, Inc., 1630 Edmondson Ave.,	



# FUNERAL DIRECTOR: IMPORTANT

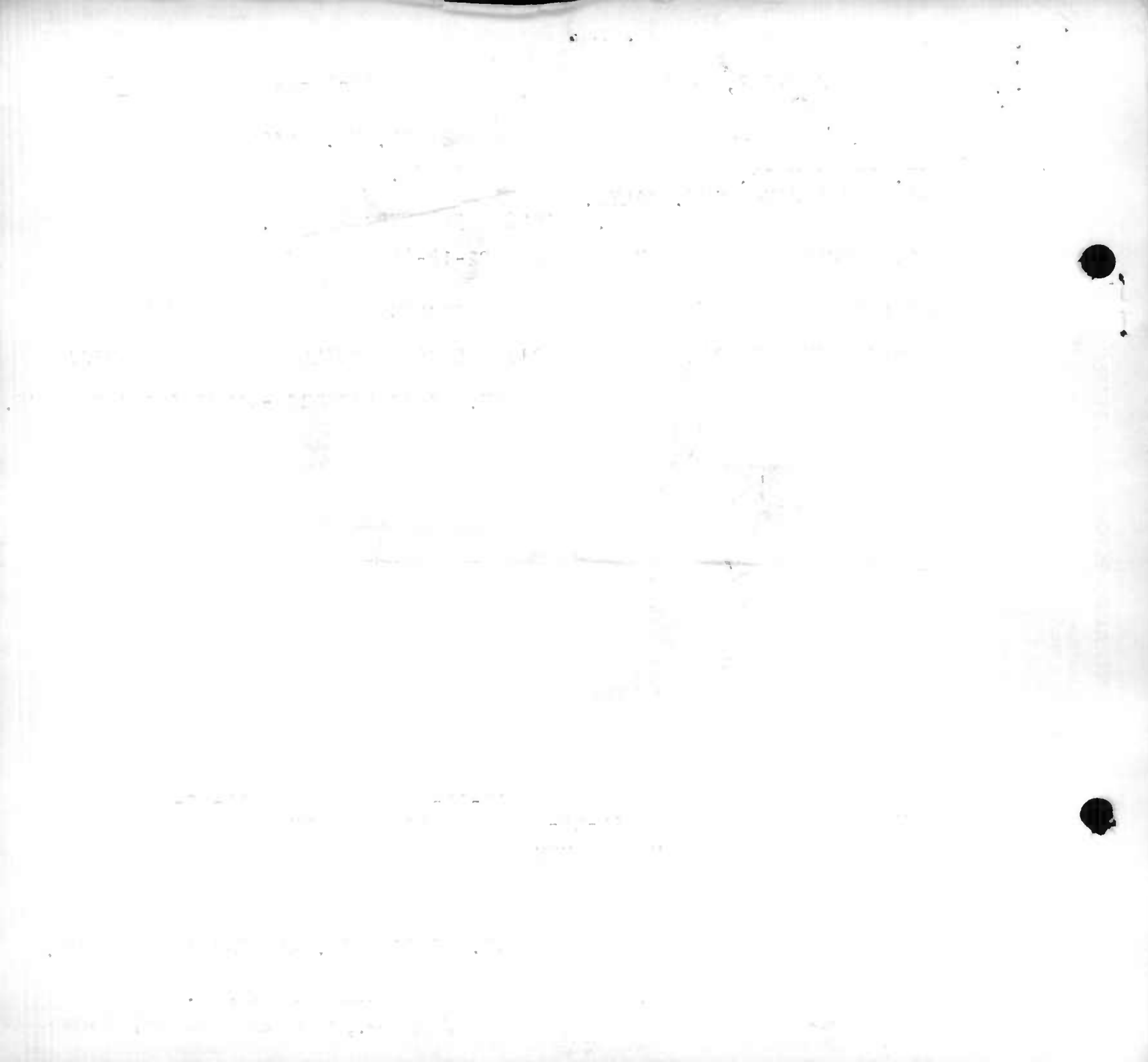
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

69 12741 BALTIMORE CITY HEALTH DEPARTMENT  
**CERTIFICATE OF DEATH**

REG. NO.

69 12741

BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		STEVENS, NORA		12-23-69 9 30 A M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE B. COUNTY	
ST. AGNES HOSP. WILKENS & CATON AVE. BALTO. MD. 21228				BALTO. MD. 21228	
				C. CITY OR TOWN D. INSIDE CITY LIMITS?	
				BALTO. YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX 6. RACE 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH 9. AGE (In years lost birthday)	
FEMALE WHITE				02-14-84 85	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				11. BIRTHPLACE (State or foreign country)	
RETIRED				MARYLAND	
10B. KIND OF BUSINESS OR INDUSTRY				12. CITIZEN OF WHAT COUNTRY?	
				USA	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME	
JOSEPH CHAMBERLAIN DEC'D				ANNA FRETWELL BEED	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.	
17. INFORMANT				ADDRESS	
				ST. AGNES RECORDS -WILKENS & CATON AVE.	
18. CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH					
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)					
ANTECEDENT CAUSES					
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
<p>410.4 I</p> <p><i>pulmonary embolism?</i></p> <p><i>Myocardial infarction.</i></p> <p>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:</p> <p>(B) DUE TO, OR AS A CONSEQUENCE OF:</p> <p>(C) DUE TO, OR AS A CONSEQUENCE OF:</p>					
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
				NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 12-17-19 69 to 12-23-19 69 that (X) (we) last saw the deceased alive on 12-23-19 69 and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
J. M. A. N. G. S. M. B. C. T. M.				12/23/69	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
J. M. A. N. G. S. M. B. C. T. M.				ST. AGNES HOSP. WILKENS & CATON AVE.	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
Burial		12/26/69		St. Johns Cemetery	
24D. LOCATION (City, town, or county) (State)		24E. LOCATION (City, town, or county) (State)			
Baltimore City, Md.		Baltimore City, Md.			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
DEC 26 1969		R. E. F. B. G. M. D.		Witzke, Inc., 1630 Edmondson Ave, Catonsville	





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

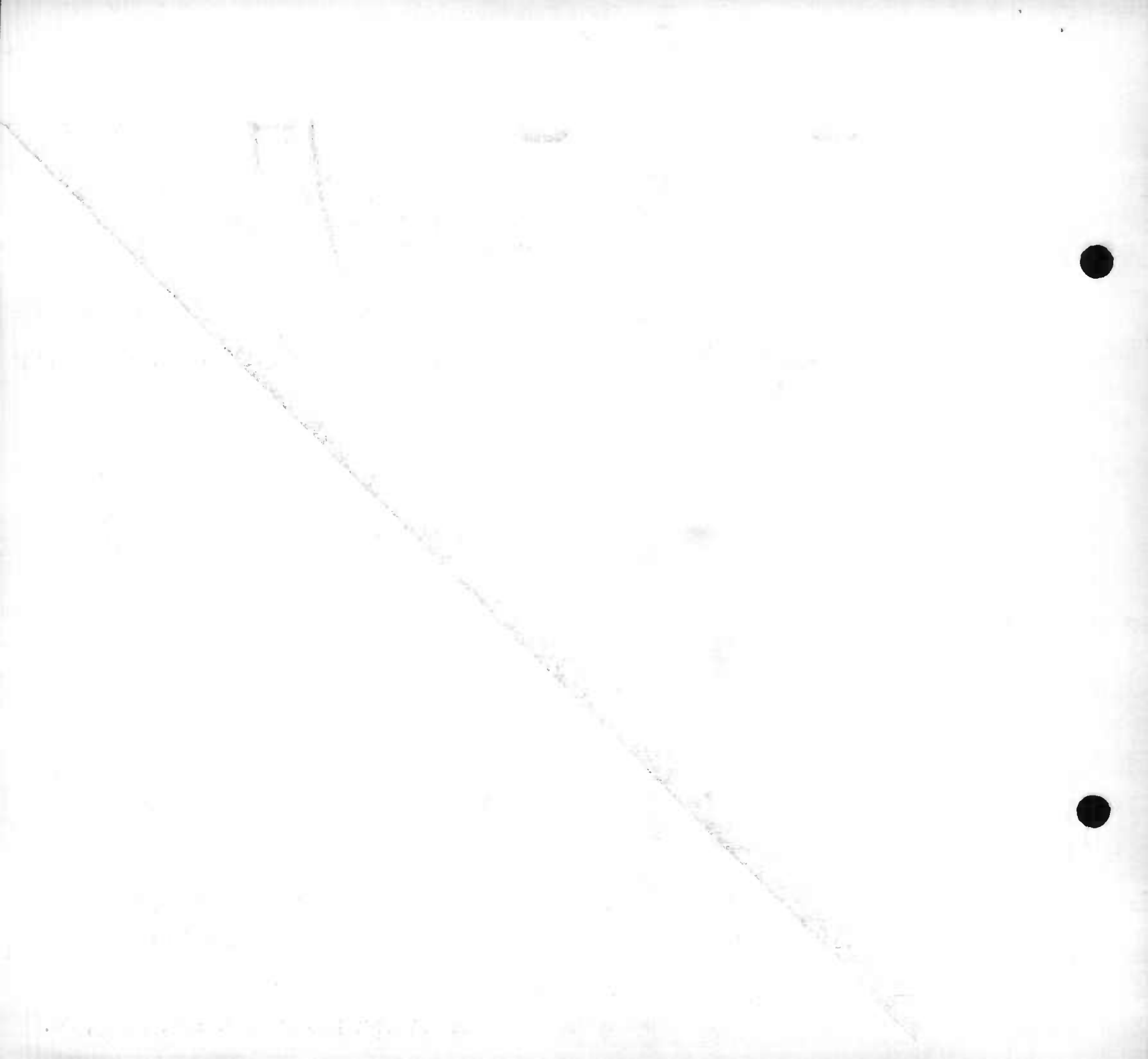
BALTIMORE CITY HEALTH DEPARTMENT				69 12742		REG. NO. 69 12742	
BIRTH NO. 69 12742				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>Weaver Edwin</u>				2. DATE AND HOUR OF DEATH <u>12/25/69</u> <u>8:40</u> P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>34 Bow Secours Hospital</u>				A. STATE <u>Md.</u>		B. COUNTY <u>Baltimore</u>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> <u>21229</u>	
5. SEX <u>M</u>				6. RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <u>03/06/01</u>				9. AGE (in years last birthday) <u>68</u>		10. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>Henry C. Weaver</u>				14. MOTHER'S MAIDEN NAME <u>Catherine Kimmell</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>unknown</u>				16. SOCIAL SECURITY NO. <u>217-07-8972</u>		17. INFORMANT <u>B. Rehman</u>	
18. CAUSE OF DEATH <u>410.94 1250.9</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Diabetes Mellitus</u>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH (A) IMMEDIATE CAUSE <u>Acute myocardial infarction 1 day</u> <u>E.C.H.F.</u> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:			
19. DATE OF OPERATION <u>0</u>				20A. AUTOPSY? (Yes or No) <u>No</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>Dec 25</u> 19 <u>69</u> to <u>Dec 25</u> 19 <u>69</u> that (I) (we) last saw the deceased alive on <u>Dec 25</u> 19 <u>69</u> and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Inkum Shin M.D.</u>				23B. DATE SIGNED <u>Dec. 25, 1969</u>		23C. PHYSICIAN'S NAME (Type) <u>INKUM SHIN M.D.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>				24B. DATE <u>12/29/69</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cemetery</u>	
24D. LOCATION <u>Baltimore, Md.</u>				24E. FUNERAL DIRECTOR <u>Witzke, Inc.</u>		24F. ADDRESS <u>1630 Edmondson Ave., 21228</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>DEC 26 1969</u>				25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>		25C. FUNERAL DIRECTOR <u>Witzke, Inc.</u>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

69 12743		BALTIMORE CITY HEALTH DEPARTMENT		X REG. NO.		69 12743	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>RUTH ELIZ HENSHAW</b>		2. DATE AND HOUR OF DEATH <b>DEC 24, 69, 1/20 P.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <b>BALTIMORE, MD.</b> B. COUNTY <b>5300</b>		C. CITY OR TOWN <b>BALTIMORE MD.</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION <b>UNIVERSITY OF MARYLAND HOSPITAL</b> <b>38</b>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		E. STREET AND NUMBER <b>1759 CHOMPLAIN Dr.</b>			
5. SEX <b>F</b>	6. RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>8/29/10</b>	9. AGE (In years last birthday) <b>59</b>	10. Under 1 Yr. Months Days Hours Min. If Under 24 Hrs. Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>TEACHER</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Ua.</b>		12. CITIZEN OF WHAT COUNTRY? <b>FRANCE U.S.A.</b>	
13. FATHER'S NAME <b>DANIEL HENSHAW</b>		14. MOTHER'S MAIDEN NAME <b>ELIZABETH BLANKENBAKER</b>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
18. <b>I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>POSS. PULMONARY EMBOLISM</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>SEVERAL YEARS</b>		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 DAYS</b>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <b>CARCINOMA OF THE CERVIX</b> DUE TO, OR AS A CONSEQUENCE OF:		(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <b>12/16/69</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Recurrent CP of Cervix</b>		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>DEC 14 1969</b> to <b>DEC 24 1969</b> that (I) (we) last saw the deceased alive on <b>DEC 24 1969</b> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Gerardo Araiza</b>		23B. DATE SIGNED <b>12/24/69</b>		23C. PHYSICIAN'S NAME (Type) <b>GERARDO ARAIZA</b>		23D. ADDRESS <b>UNIVERSITY OF MD. HOSPITAL</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12/27/69</b>		24C. NAME OF CEMETERY or CREMATORY <b>Hebron Lutheran Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Madison, Virginia</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 26 1969</b>		25B. NAME OF REGISTRAR <b>Robert E. Sabey, M.D.</b>		25C. FUNERAL DIRECTOR <b>Witzke, 42010</b>		ADDRESS <b>Edmondson Avenue, Balto, Md. 21229</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 69 12744				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 69 12744	
1. NAME OF DECEASED (Type or Print) Alex I. Itzkoff				2. DATE AND HOUR OF DEATH December 22/69 6A M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 90 Pleasant Manor Nursing Home				A. STATE Maryland		B. COUNTY 1510	
				C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 4002 Ardale Ave			
5. SEX Male	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 17, 1883	9. AGE (In years last birthday) 86	If Under 1 Yr. Months: Days: Hours: Min.	If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Presser				10B. KIND OF BUSINESS OR INDUSTRY Ladies Mens Clothing		11. BIRTHPLACE (State or foreign country) Russia	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Yitzhak Itzkoff				14. MOTHER'S MAIDEN NAME Chai Suwa			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. A 215-03-6829		17. INFORMANT Mrs Lena Snyder-4001 Parkway	
18. 410.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Coronary Thrombosis AICVD (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: Cholesterol & Arteriosclerosis Benign Prostatic Hyperplasia Heart		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes years 1 yr	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION 01/11/69		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Cholecystitis, BPH		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 1965 19 to 12/22/69 19 that (I) (we) last saw the deceased alive on 12/11/69 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Joseph Shear MD				23B. DATE SIGNED 12/22/69		23C. PHYSICIAN'S NAME (Type) Joseph Shear MD	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial				24B. DATE 12-24-69		24C. NAME OF CEMETERY or CREMATORY Ridgewood Young Men	
24D. LOCATION Woodlawn, Md				25A. DATE REC'D BY HEALTH DEPT. DEC 26 1969			
25B. NAME OF REGISTRAR Robert E. Talley, M.D.				25C. FUNERAL DIRECTOR Sally Pearson - 6010 West Rd			

FOOT

ALLIE



69 12745

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

69 12745

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

BESSIE ZABEN

2. DATE  
OF  
DEATHKnown ☐ Estimated ☐Month  
Day

Year

Hour

8:25 P.M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

39 Provident Hospital

3. DATE  
PRONOUNCED DEAD

Month

Day

Year

Hour

8:25 P.M.

December 23, 1969

5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE

Maryland

B. COUNTY

53-00

6. SEX

Female

7. RACE

White

8. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

C. CITY OR TOWN

Balto.

D. INSIDE CITY LIMITS?

YES ☐NO ☒

9. DATE OF BIRTH

2-20-07

10. AGE (In years  
last birthday)

62

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.

E. STREET AND NUMBER

8007 YORK ROAD 2818 RONA ROAD #07

11. BIRTHPLACE (State or foreign country)

POLAND

12. CITIZEN OF  
WHAT COUNTRY?

USA

13. FATHER'S NAME

BEN BIEN

14A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

HOUSEWIFE

14B. KIND OF BUSINESS OR INDUSTRY

AT HOME

15. MOTHER'S MAIDEN NAME

LENA?

16. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

NO

17. SOCIAL  
SECURITY NO.

071-20-6962

18. INFORMANT

MR. ALBERT ZABEN, 2818 RONA ROAD #07

ADDRESS

19. DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

(A) IMMEDIATE CAUSE Multiple traumatic injuries  
DUE TO, OR AS A CONSEQUENCE OF:

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C) DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES  
DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART I (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

YES

22A. EXTERNAL CAUSE WAS  
UNDERLYING ☒ OR CONTRIB-  
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg., etc.)  
Street22C. WHERE DID (if in Baltimore City, give exact location)  
INJURY OCCUR?

Intersection of Penna. Ave. &amp; Clifton Av

22D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY (APPROX.)

12

23

69

6:45

22E. INJURY OCCURRED  
WHILE AT WORK ☐NOT WHILE  
AT WORK ☒

22F. HOW DID INJURY OCCUR?

Pedestrian struck by auto

23.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATUREEXAMINER'S  
NAME (Type)

Ronald N. Kornblum, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

12/24/69

24A. BURIAL CREMATION,  
REMOVAL (Specify)

BURIAL

24B. DATE

12-24-69

24C. NAME OF CEMETERY or CREMATORY

AITZ CHAIN, WASHINGTON BLVD. MARYLAND

24D. LOCATION

(City, town, or county)

(State)

25A. DATE REC'D BY HEALTH DEPT.

DEC 26 1969

25B. NAME OF REGISTRAR

R. E. Zablen, M.D.

25C. FUNERAL DIRECTOR

ADDRESS

SOL LEWINSON &amp; BROS. 6010 REISTERSTOWN RD.

10-1-68

UNITED STATES DEPARTMENT OF JUSTICE

TO: SAC, NEW YORK

FROM: SAC, NEW YORK

SUBJECT: [Illegible]

RE: [Illegible]

DATE: 10-1-68

BY: [Illegible]

FOR: [Illegible]

THRU: [Illegible]

INFO: [Illegible]

ATTN: [Illegible]

COPIES: [Illegible]

ENCLOSURES: [Illegible]

COMMENTS: [Illegible]

ADMINISTRATIVE: [Illegible]

OTHER: [Illegible]

REMARKS: [Illegible]

SIGNATURE: [Illegible]

TITLE: [Illegible]

DEPARTMENT: [Illegible]

OFFICE: [Illegible]

LOCATION: [Illegible]

STATUS: [Illegible]

REMARKS: [Illegible]

DATE: 10-1-68

NEW YORK

NEW YORK

NEW YORK

AT NEW YORK

AT NEW YORK

NO. 100-100000, NEW YORK, NEW YORK

NO. 100-100000, NEW YORK, NEW YORK

RE: [Illegible]

RE: [Illegible]

RE: [Illegible]

RE: [Illegible]

RE: [Illegible]

RE: [Illegible]

RE: [Illegible]

RE: [Illegible]

RE: [Illegible]

RE: [Illegible]

RE: [Illegible]

RE: [Illegible]

RE: [Illegible]

RE: [Illegible]

RE: [Illegible]

RE: [Illegible]

RE: [Illegible]

UNITED STATES DEPARTMENT OF JUSTICE

10-1-68

NEW YORK

RE: [Illegible]



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

A-140

69 12746

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

X REG. NO. 69 12746

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>DAVID APPLE</b>		2. DATE AND HOUR OF DEATH <b>12-23-69 12:52 A.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>42 Sinai Hospital</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTIMORE</b> C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>6984 MILLBROOK PARK DR.</b>	
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1-13-16</b>	9. AGE (In years last birthday) <b>53</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Merchant</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Retail</b>		11. BIRTHPLACE (State or foreign country) <b>Balt. Ind</b>	
13. FATHER'S NAME <b>Maurice Apple</b>			14. MOTHER'S MAIDEN NAME <b>Mary Offenberg</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes WWII ARMY</b>		16. SOCIAL SECURITY NO. <b>212-18-7293</b>		17. INFORMANT <b>Mrs. Inez Apple</b> ADDRESS <b>6984 Millbrook Park Drive #15</b>	
18. <b>410.9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b> <b>ENDEMIC ACUTE PULMONARY</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b> <b>MYOCARDIAL INFARCTION</b> <b>ATHEROSCLEROTIC DISEASE</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>HOURS</b> <b>HOURS</b> <b>YEARS</b>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>12-22-69</b> to <b>12-23</b> 19 <b>69</b> that (I) (we) last saw the deceased alive on <b>12-23</b> 19 <b>69</b> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Weyant MD</b>				23B. DATE SIGNED <b>12-23-69</b>	
23C. PHYSICIAN'S NAME (Type) <b>RUBEN DEJANSKI MD</b>				23D. ADDRESS <b>Sinai Hospital Balto</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12-24-69</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Baltimore Hebrew</b>	
24D. LOCATION (City, town, or county) (State) <b>Belair Road, Maryland</b>		25A. DATE REC'D BY HEALTH DEPT. <b>DEC 26 1969</b>			
25B. NAME OF REGISTRAR <b>Paul E. Taber MD</b>		25C. FUNERAL DIRECTOR <b>6010 828 Junction &amp; Bus. Reisterstown Rd.</b>			



R-543

1

BALTIMORE CITY HEALTH DEPARTMENT

## 69 12747 CERTIFICATE OF DEATH

REG. NO. 69 12747

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

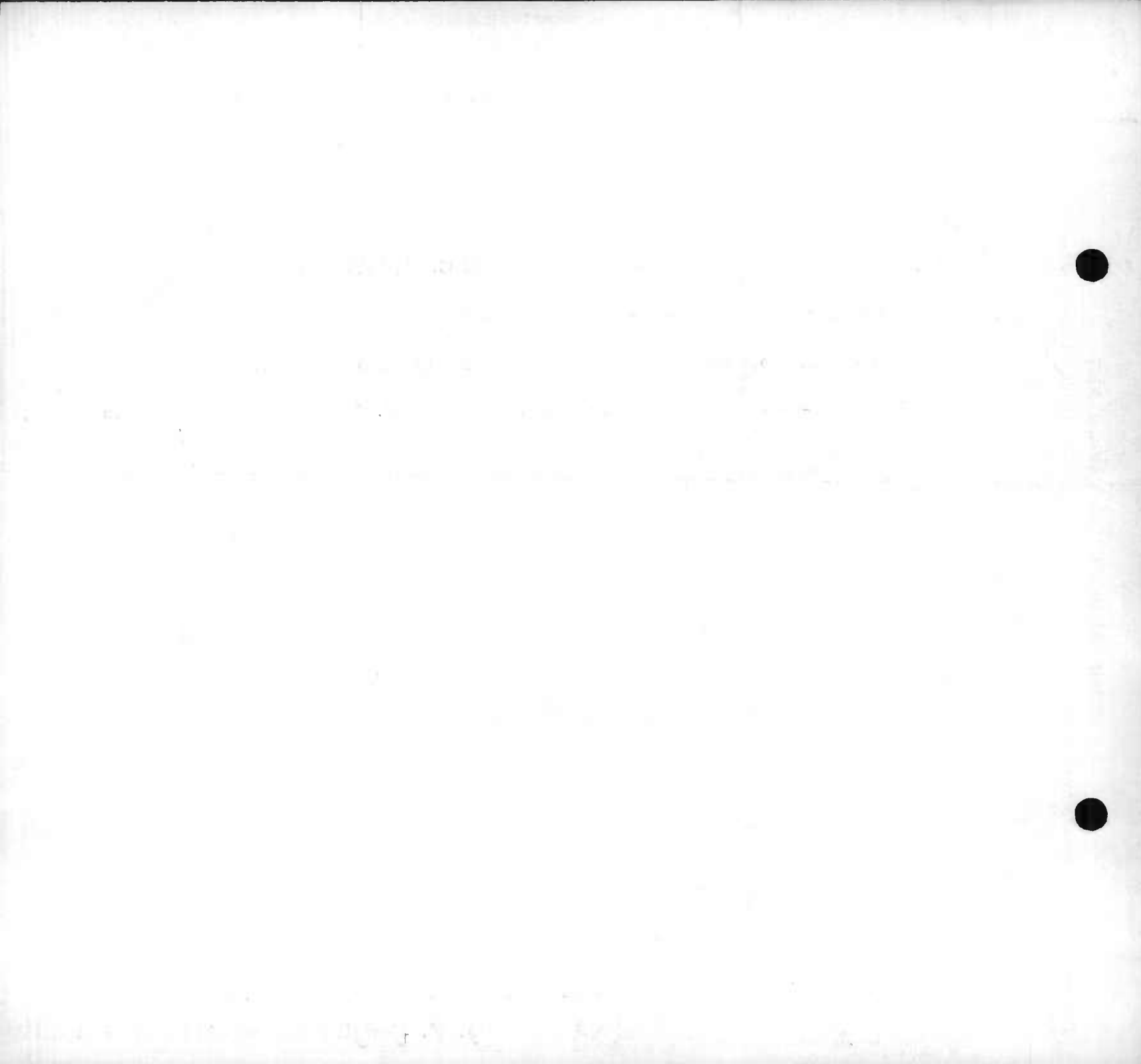
BIRTH NO.		69 12747	
1. NAME OF DECEASED (Type or Print) <i>Reynolds Monica C.</i>		2. DATE AND HOUR OF DEATH <i>12/20/69 9:00 a.m.</i>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION <i>34 Bon Secours Hospital</i>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>MD.</i> B. COUNTY <i>2006 HOLLINS STREET</i> C. CITY OR TOWN <i>BALTIMORE</i> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> <i>2003</i> E. STREET AND NUMBER <i>2006 HOLLINS STREET</i>	
5. SEX <i>F</i>	6. RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>10/25/85</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Nursing Service</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Hospital</i>	9. AGE (In years last birthday) <i>84</i>
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S. A.</i>	
13. FATHER'S NAME <i>THOMAS REYNOLDS</i>		14. MOTHER'S MAIDEN NAME <i>CALAHAN, Elisha</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>NO</i>		16. SOCIAL SECURITY NO. <i>220 30 2423</i>	
17. INFORMANT <i>Hospital Records of Bon Secours Hospital</i>		ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <i>Septicemia</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>Subdiaphragmatic abscess + asc. cholangitis 1 week</i>		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Sl p. resection of stomach for carcinoma?</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <i>ASCVD</i>			
19A. DATE OF OPERATION <i>11-24-69</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) <i>No</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I certify that (H) (this hospital) attended the deceased from <i>NOVEMBER 10 1969</i> to <i>DECEMBER 20 1969</i> that (I) (we) last saw the deceased alive on <i>DECEMBER 19 1969</i> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <i>Sam B. Kerr MD ChB (EDIN)</i>		23B. DATE SIGNED <i>12/20/69</i>	
23C. PHYSICIAN'S NAME (Type) <i>IAIN C. KERR MD ChB</i>		23D. ADDRESS <i>BON SECOURS HOSPITAL 2025 W. FAYETTE ST BALTO #23</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>23 DEC 69</i>	
24C. NAME of CEMETERY or CREMATORY <i>St. Patrick's Cemetery</i>		24D. LOCATION (City, town, or county) (State) <i>Mt. Sayage, Maryland</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>DEC 26 1969</i>		25B. NAME OF REGISTRAR <i>Robert E. Fisher, MD</i>	
25C. FUNERAL DIRECTOR <i>J. E. Lowell Lemmon</i>		ADDRESS <i>4611 Park Heights Ave</i>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

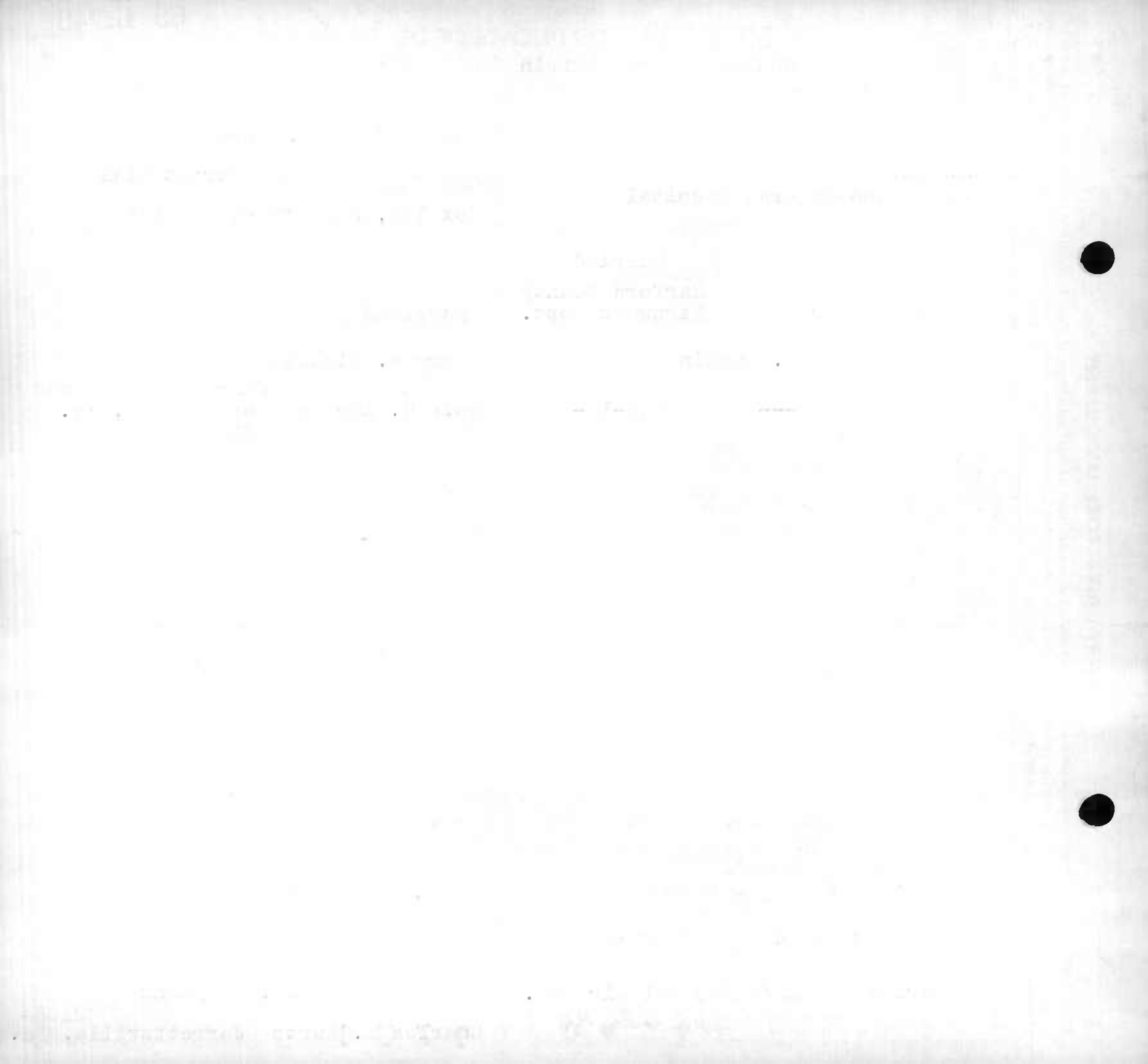
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="float: right;">69 12748</span>			
69 12748				CERTIFICATE OF DEATH			
BIRTH NO.				1. NAME OF DECEASED (Type or Print) <b>WUNDER VERONICA JOSEPHINE</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				2. DATE AND HOUR OF DEATH <b>12-22-69 11:15 AM</b>			
FULL NAME OF HOSPITAL OR INSTITUTION <b>42 SINAI HOSPITAL OF BALTO.</b>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>1513</b>		C. CITY OR TOWN <b>BALTIMORE</b>	
5. SEX <b>F</b>		6. RACE <b>W</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>DEC. 11, 1896</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Homemaker</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>- - -</b>		9. AGE (In years last birthday) <b>73</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>Bernard J. Hogarty</b>				14. MOTHER'S MAIDEN NAME <b>Mary Ellen Donnelly</b>			
15. Was Deceased Ever in U. S. Armed Forces? (If yes, no or unknown) (If yes, give war or dates of service) <b>NO - - -</b>		16. SOCIAL SECURITY NO. <b>578 09 6567</b>		17. INFORMANT <b>Bernard J. Wunder PO Box 4021 Columbia,</b>		ADDRESS <b>S. C.</b>	
18. <b>593.2 I</b> CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>(A) IMMEDIATE CAUSE CARDIAC ARREST</b> DUE TO, OR AS A CONSEQUENCE OF:							
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>(B) <del>ACUTE</del> ACUTE RENAL INSUFF.</b> DUE TO, OR AS A CONSEQUENCE OF: <b>4 days</b>							
<b>(C) SHOCK</b> DUE TO, OR AS A CONSEQUENCE OF: <b>4 days</b>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>CHOLECYSTITIS &amp; A.S.C.V.D.</b>				<b>YEARS</b>			
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>12-4 19 69</b> to <b>12-22 19 69</b> that (I) (we) lost saw the deceased alive on <b>12-22 19 69</b> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>W. Hatten M.D. (912)</b>				23B. DATE SIGNED <b>12-22-69</b>		23C. PHYSICIAN'S NAME (Type) <b>CARLOS S. VALLEJOS M.D.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>				24B. DATE <b>24 DEC 69</b>		24C. NAME OF CEMETERY or CREMATORY <b>New Cathedral Cemetery</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 26 1969</b>				25B. NAME OF REGISTRAR <b>Robert E. Taylor, M.D.</b>		25C. FUNERAL DIRECTOR <b>J. E. Powell Lemmon</b>	
24D. LOCATION <b>Baltimore, Maryland</b>				ADDRESS <b>4611 Park Heights</b>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 69 12749		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 69 12749	
M.E. CASE NO.		1. NAME OF DECEASED Justice Henry Amrein		2. DATE AND HOUR OF DEATH 12/25/69 4:40 P.M.	
(Type or Print) AMREIN, J. HENRY		3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION Maryland General Hospital		(If not in hospital or institution, give street address or location)		A. STATE Maryland B. COUNTY Harford C. CITY OR TOWN (If outside city limits, write RURAL and give township) Forest Hill Md Forest Hill	
5. SEX M		6. RACE White		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Supervisor		10B. KIND OF BUSINESS OR INDUSTRY Harford County Highways Dept.		8. DATE OF BIRTH 3/29/99	
13. FATHER'S NAME Charles H. Amrein		14. MOTHER'S MAIDEN NAME Mary A. Eicholtz		9. AGE (In years last birthday) 70	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No ---		16. SOCIAL SECURITY NO. 218-18-3548		11. BIRTHPLACE (State or foreign country) Maryland	
17. INFORMANT Rosie H. Amrein		ADDRESS Jarrettsville Road Forest Hill, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
18. 569.9 I		CAUSE OF DEATH 21050		INTERVAL BETWEEN ONSET AND DEATH 9 DAYS	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		(A) Renal Failure DUE TO		= 9 DAYS	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(B) Gastrointestinal Bleeding DUE TO		= 9 DAYS	
ANTECEDENT CAUSES		(C)			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION 11/25/69		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED chronic cholelithiasis		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
22. I certify that (H) (this hospital) attended the deceased from 12/18/69 to 12/25/69		that (H) (we) last saw the deceased alive on 12/25 1969		and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (H) (We) (did) (did not) view the body after death.	
23A. SIGNATURE Frank N. Turner		M.D. Attending Phys. Mod. Director Staff Phys. (X)		23B. DATE SIGNED 12/25/69	
23C. PHYSICIAN'S NAME (Type) FRANK N. TURNER		23D. ADDRESS Maryland General Hospital			
24A. BURIAL CREMATION REMOVAL (Specify) Burial		24B. DATE 12/29/69		24C. NAME of CEMETERY or CREMATORY Bel Air Mem. Gardens	
24D. LOCATION (City, town, or county) Bel Air, Maryland		(State)			
25A. DATE REC'D BY HEALTH DEPT. DEC 26 1969		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Charles E. Kurtz	
25D. ADDRESS 21084		Jarrettsville, Md.			





C-240

## BALTIMORE CITY HEALTH DEPARTMENT

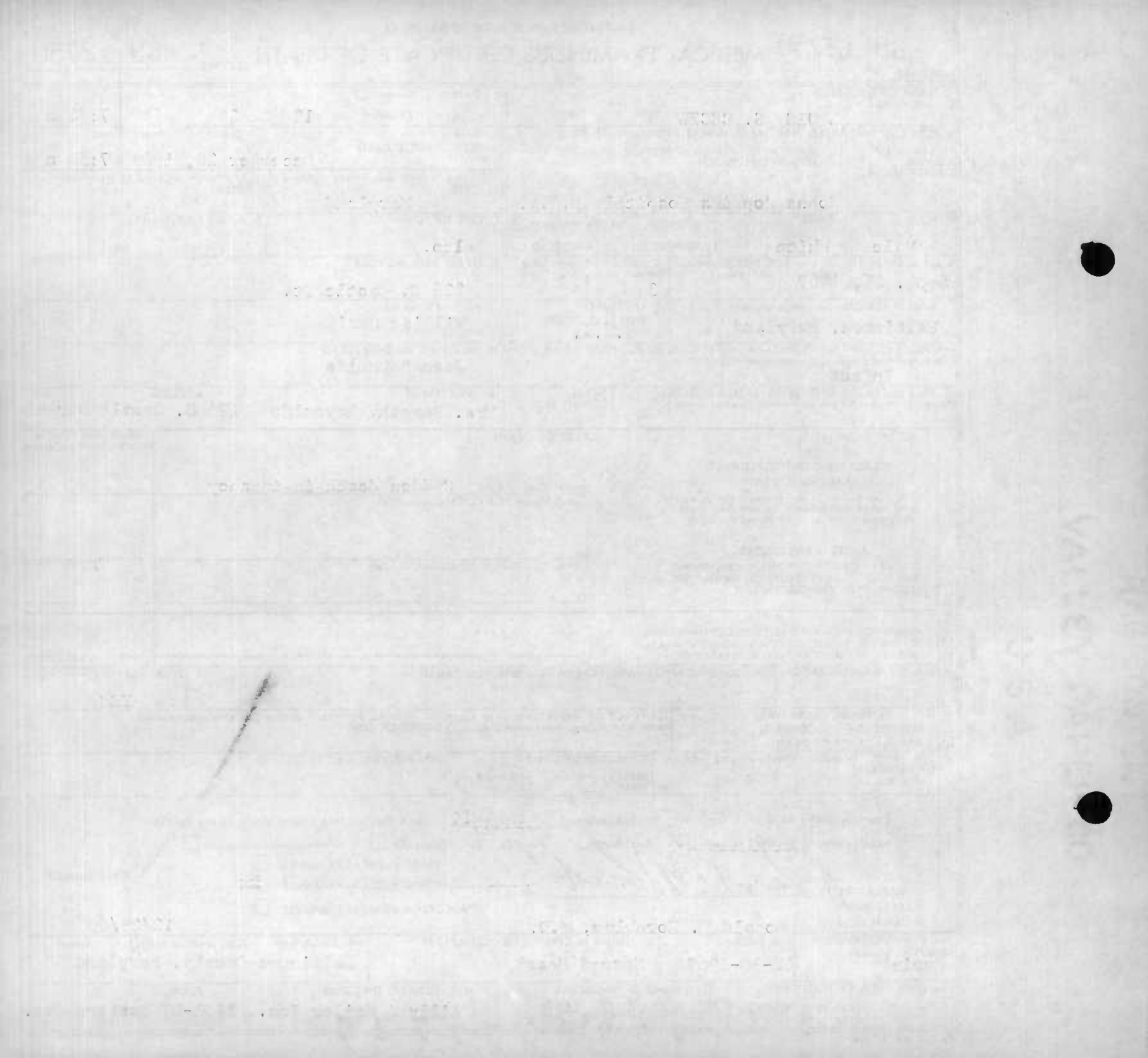
69 12750

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 69 12750

BIRTH NO. 69-17251

1. NAME OF DECEASED (Type or Print) <b>LOUIS S. CECIL</b>		2. DATE OF DEATH Known <input type="checkbox"/> Estimated <input type="checkbox"/> <b>12 28 69</b> Month Day Year		Hour <b>7:58 a. M.</b>	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>Johns Hopkins Hospital D.O.A.</b>		3. DATE PRONOUNCED DEAD Month Day Year <b>December 28, 1969</b>		Hour <b>7:58 a. M.</b>	
6. SEX <b>Male</b>		7. RACE <b>White</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH <b>Sept. 25, 1969</b>		10. AGE (In years last birthday) <b>3</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>	
12. CITIZEN OF <b>U.S.A.</b>		13. FATHER'S NAME <b>William Cecil</b>		14. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>201</b>	
15. MOTHER'S MAIDEN NAME <b>Jean Reynolds</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.	
18. INFORMANT <b>Mrs. Dorothy Reynolds</b>		ADDRESS <b>226 S. Castle Street</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		(A) IMMEDIATE CAUSE <b>Sudden death in infancy</b> DUE TO, OR AS A CONSEQUENCE OF: (B) _____ DUE TO, OR AS A CONSEQUENCE OF: (C) _____			
20A. DATE OF OPERATION <b>2</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) <b>YES</b>	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <b>Ronald N. Kornblum</b> M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) <b>Ronald N. Kornblum, M.D.</b> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <b>12/28/69</b> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>					
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12-30-1969</b>		24C. NAME OF CEMETERY or CREMATORY <b>Sacred Heart</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore County, Maryland</b>		25A. DATE REC'D BY HEALTH DEPT. <b>DEC 26 1969</b>		25B. NAME OF REGISTRAR <b>Philip E. Faber, M.D.</b>	
25C. FUNERAL DIRECTOR <b>Lilly &amp; Zeiler Inc.</b>		ADDRESS <b>1901-07 Eastern Ave.</b>			



69 12751

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 69 12751

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Theodore Hicks

2. DATE  
OF  
DEATHKnown ☒  
Estimated ☐

Month

Day

Year

Hour

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

Hopkins Hospital

3. DATE  
PRONOUNCED DEAD

Month

Day

Year

Hour

M.

5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE

B. COUNTY

Maryland

Clavert Co.

6. SEX

male

7. RACE

colored

B. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

C. CITY OR TOWN

Prince Frederick

D. INSIDE CITY LIMITS?

YES ☐NO ☒

9. DATE OF BIRTH

5 - 7 - 46

10. AGE (In years  
less birthday)

23

11. Under 1 Yr. 11 Under 24 Hrs.  
Months Days Hours Min.

E. STREET AND NUMBER

Rte. 1 Box 75

11. BIRTHPLACE (State or foreign country)

Md

12. CITIZEN OF  
WHAT COUNTRY?

USA

13. FATHER'S NAME

Theodore Hicks Sr.

14A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Labor

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Marie Smith

16. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, No or unknown) (If yes, give war or dates of service)17. SOCIAL  
SECURITY NO.

219-46-5771

18. INFORMANT

ADDRESS

Rose Marie Hicks-St. Leonard- Md

19.

CAUSE OF DEATH

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) IMMEDIATE CAUSE Acute and subacute bacterial  
DUE TO, OR AS A CONSEQUENCE OF: endocarditis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) Gunshot wounds

(C) DUE TO, OR AS A CONSEQUENCE OF:

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART 1 (A).

MEDICAL CERTIFICATION

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

yes

22A. EXTERNAL CAUSE WAS  
UNDERLYING ☒ OR CONTRIB-  
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., In or about  
home, farm, factory, street, office bldg., etc.)

home

22C. WHERE DID (If in Baltimore City, give exact location)

Rte. 1 Box 75 Prince Frederick

22D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY (APPROX.)

10 25 69 ?

22E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☒

22F. HOW DID INJURY OCCUR?

shot with rifle

23.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐ACTUAL  
SIGNATURE

EXAMINER'S

NAME (Type)

Werner U. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☐

Deputy Chief Medical Examiner

DATE SIGNED

12/23/69

24A. BURIAL CREMATION,  
REMOVAL (Specify)

24B. DATE

12-28-69

24C. NAME OF CEMETERY or CREMATORY

Patuxent Ch. Cem

24D. LOCATION (City, town, or county)

Huntingtown

Md

25A. DATE REC'D BY HEALTH DEPT.

DEC 26 1969

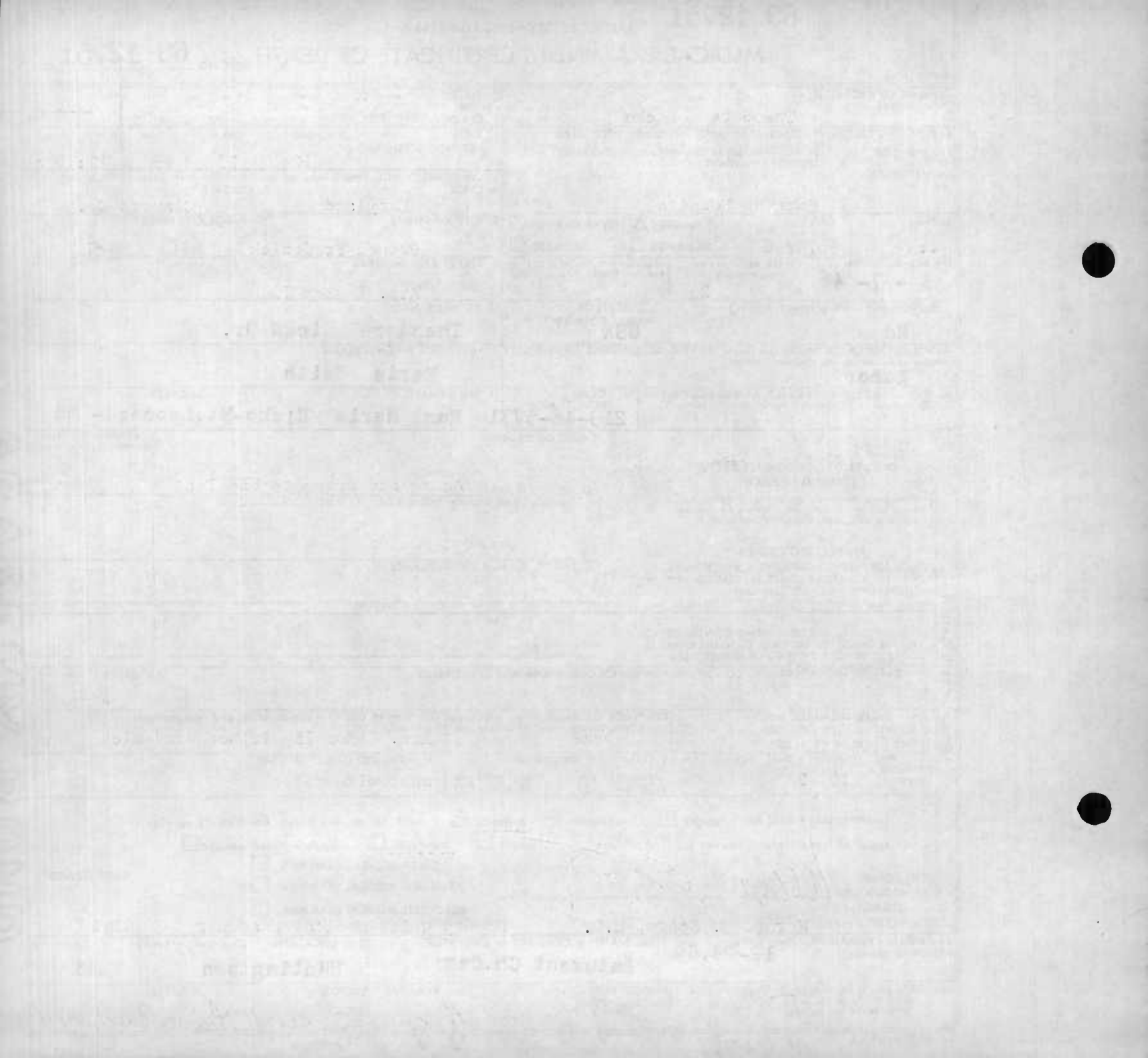
25B. NAME OF REGISTRAR

Robert E. Taylor, R.D.

25C. FUNERAL DIRECTOR

ADDRESS

Linker E. Seewell, Prince Fred, Md



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

X-150 69 12752				BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 69 12752	
1. NAME OF DECEASED (Type or Print) <b>ALEXANDER RUBIN</b>				2. DATE AND HOUR OF DEATH <b>DECEMBER 19, 1969</b> <span style="float: right;">11<sup>30</sup> A.M.</span>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  <b>42 SINAI HOSPITAL</b>				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>2716</b> C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>4825 REISTERSTOWN ROAD #21215</b>			
5. SEX <b>MALE</b>	6. RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>75</b>		9. AGE (In years lost birthday)	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CHAUFFER</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>TAXI</b>		11. BIRTHPLACE (State or foreign country) <b>BALTIMORE, MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>JACOB RUBIN</b>				14. MOTHER'S MAIDEN NAME <b>RACHIE SHULMAN</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>MR. HARRY RUBIN</b> ADDRESS <b>TWO CHARLES CENTER, APTS. 1202 8 CHARLES PLAZA #21201</b>			
18. <b>250.9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.  <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				CAUSE OF DEATH <b>Acute pulmonary Infection</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>arteriosclerotic Heart disease</b> (B) DUE TO, OR AS A CONSEQUENCE OF: <b>Diabetes Mellitus</b> (C) <b>none</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b> <b>5 years</b> <b>20 years</b>	
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>no</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <b>May 26, 1948</b> to <b>Dec 19, 1969</b> , that (I) ( <del>we</del> ) last saw the deceased alive on <b>Dec 19, 1969</b> and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>we</del> ) (did) ( <del>did not</del> ) view the body after death.							
23A. SIGNATURE <b>Manuel Levin</b>				23B. DATE SIGNED <b>12/20/69</b>		23C. PHYSICIAN'S NAME (Type) <b>DR. MANUEL LEVIN</b>	
23D. ADDRESS <b>6101 PARK HEIGHTS AVENUE</b>							
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>12-21-69</b>		24C. NAME OF CEMETERY or CREMATORY <b>WORKMENS CIRCLE</b>		24D. LOCATION (City, town, or county) (State) <b>GERMAN HILL ROAD, MARYLAND</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 29 1969</b>		25B. NAME OF REGISTRAR <b>Charles E. Taylor, M.D.</b>		25C. FUNERAL DIRECTOR ADDRESS <b>SOL LEVINSON &amp; BROS. 6010 REISTERSTOWN ROAD</b>			

10-11-44

WHITE

X

CHARTER

DAY

10-11-44

WHITE

ST. MARKS CHURCH, BALTIMORE, MD.  
10-11-44

ST. MARKS CHURCH

ST. MARKS CHURCH

10-11-44

ST. MARKS CHURCH

ST. MARKS CHURCH



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <b>69 12753</b>	
BIRTH NO. <b>N-233 69 12753</b>		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <b>SIDNEY NEISTADT</b>		2. DATE AND HOUR OF DEATH <b>DECEMBER 19, 1969</b> <b>9:15 P. M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>42 SONAI HOSPITAL</b>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTIMORE</b> C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>6307 PIMLICO ROAD #21209</b>	
5. SEX <b>MALE</b>	6. RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>58</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SALESMAN</b>		11. BIRTHPLACE (State or foreign country) <b>BALTIMORE, MARYLAND</b>	
10B. KIND OF BUSINESS OR INDUSTRY <b>RETAIL</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>HARRY NEISTADT</b>		14. MOTHER'S MAIDEN NAME <b>REBECCA OZER</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>MRS. FRANCES NEISTADT, 6307 Pimlico Road #09</b>		ADDRESS	
18. <b>410.9 + 1 250.9</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>Acute myocardial infarction</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Acute myocardial infarction</b> (B) <b>Acute Left wall m. I</b> DUE TO, OR AS A CONSEQUENCE OF: (C) _____	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>Diabetes Mellitus</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>sudden</b> <b>July 26, 1968</b> <b>10 years</b>	
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>June 9 1947</b> to <b>Dec. 19 1969</b> , that (I) (we) last saw the deceased alive on <b>Oct. 30 1969</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <b>A. A. Silver</b>		23B. DATE SIGNED <b>12-20-69</b>	
23C. PHYSICIAN'S NAME (Type) <b>A. A. SILVER</b>		23D. ADDRESS <b>6210 PARK HEIGHTS AVENUE</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>12-21-69</b>	
24C. NAME OF CEMETERY or CREMATORY <b>TIFERETH ISRAEL ANSHE SFARD</b>		24D. LOCATION (City, town, or county) (State) <b>ROSEDALE, MARYLAND</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 29 1969</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>	
25C. FUNERAL DIRECTOR <b>SOL LEVINSON &amp; BROS.</b>		ADDRESS <b>6010 REISTERSTOWN ROAD</b>	

SENAI HOSPITAL

WHITE

WALKER

BARRY WELSH

WALKER, WALKER

WALKER, WALKER

WALKER, WALKER

WALKER, WALKER

WALKER, WALKER

WALKER, WALKER

WALKER, WALKER



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

L-152		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 69 12754	
BIRTH NO. 69 12754		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>LEWIS L. LEVENSON</b>			2. DATE AND HOUR OF DEATH <b>DECEMBER 19, 1969</b>		<b>8:15 A.M.</b>
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY		
FULL NAME OF HOSPITAL OR INSTITUTION <b>42 SINAI HOSPITAL</b>			C. CITY OR TOWN <b>BALTIMORE</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			E. STREET AND NUMBER <b>4109 XX FERNHILL AVENUE #15</b>		
5. SEX <b>MALE</b>	6. RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9-1-11</b>	9. AGE (In years last birthday) <b>58</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>COMPOSITER</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>SUN PAPERS</b>		11. BIRTHPLACE (State or foreign country) <b>BALTIMORE MARYLAND</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			13. FATHER'S NAME <b>JOSEPH B. LEVENSON</b>		
14. MOTHER'S MAIDEN NAME <b>ROSE?</b>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		
16. SOCIAL SECURITY NO.			17. INFORMANT <b>MRS. KAY LEVENSON, 4109 FERNHILL AVE. #15</b>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>410.91</b>			CAUSE OF DEATH APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE <b>Myocardial infarction acute</b> DUE TO, OR AS A CONSEQUENCE OF: (B) <b>Coronary sclerosis 10+ yrs</b> DUE TO, OR AS A CONSEQUENCE OF: (C) <b>Prior myocardial infarction</b>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>1953</b> 19 to <b>12/19</b> 19 <b>69</b> , that (I) (we) last saw the deceased alive on <b>12/10/69</b> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>William F. Renner</b> DEGREE				23B. DATE SIGNED <b>12/19/69</b>	
23C. PHYSICIAN'S NAME (Type) <b>WILLIAM F. RENNER</b>				23D. ADDRESS <b>3222 ST. PAUL STREET</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>12-21-69</b>		24C. NAME OF CEMETERY or CREMATORY <b>HEBREW YOUNG MEN</b>	
24D. LOCATION <b>WINDSOR MILL ROAD, MARYLAND</b>		(City, town, or county) (State)			
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 29 1969</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR <b>SOL LEVINSON &amp; BROS. 6010 REISTERSTOWN RD</b>	

UNITED STATES

4102 KA TINKLETT LANE

WHITE

DATE

2-1-11

DALLAS, TEXAS

SAN ANTONIO

COMMUNIST

JOSEPH E. LEVISON

ROBERT

U.S. SAN LEVISON, 4102 KA TINKLETT LANE

Majority of the committee

Colonel of the 10th

Great majority of the committee

12/11/12

12/10/12

William J. Fox

U.S. SAN LEVISON

COMMUNIST

DATE

12-1-11

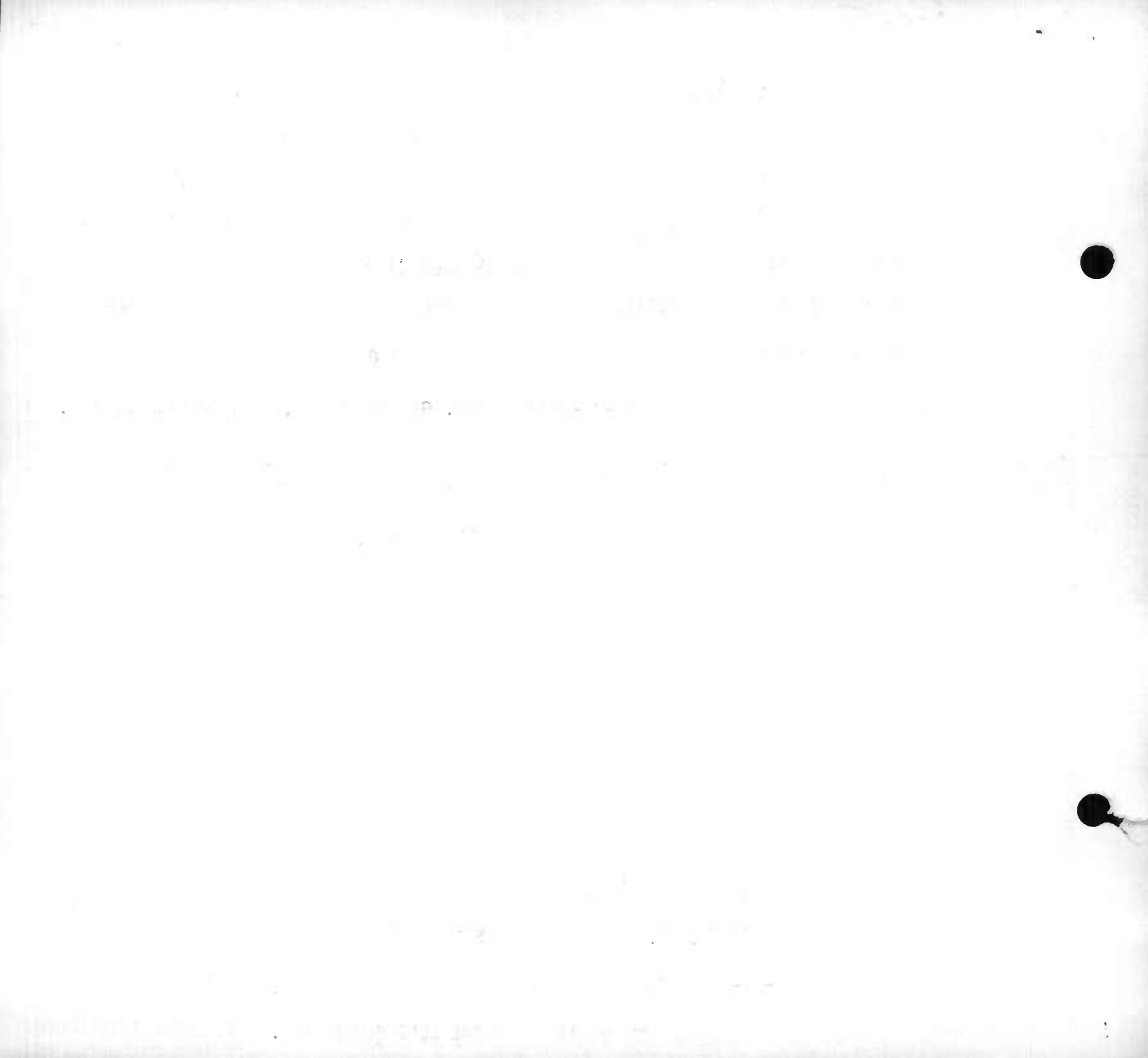
4102 KA TINKLETT LANE

U.S. SAN LEVISON, 4102 KA TINKLETT LANE

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

P-625		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 69 12755
BIRTH NO. 69 12755		2. DATE AND HOUR OF DEATH 12/18/69 1 2:20 A.M.		
1. NAME OF DECEASED (Type or Print) Leon <del>PARSON</del> PARSON		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		
FULL NAME OF HOSPITAL OR INSTITUTION Sinai Hospital		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD B. COUNTY BALTO 5300		
5. SEX MALE 6. RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SELF EMPLOYED		10B. KIND OF BUSINESS OR INDUSTRY RETAIL		
13. FATHER'S NAME ABRAHAM PARSON		14. MOTHER'S MAIDEN NAME SAPORA ?		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 218-22-9996		
17. INFORMANT ADDRESS MRS. GLADYS PARSON, 6707 LAURELWOOD AVE. #9		8. DATE OF BIRTH 10/22/04 9. AGE (in years last birthday) 65		
11. BIRTHPLACE (State or foreign country) POLAND		12. CITIZEN OF WHAT COUNTRY? USA		
18. 4 10 9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		
(This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Myocardial Infarction		
ANTECEDENT CAUSES		(B) ASCVD		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from 12/18/69 to 12/18/69 that (I) (we) last saw the deceased alive on 12/18/69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE Ellis S. Caplan MD		23B. DATE SIGNED 12/18/69		23C. PHYSICIAN'S NAME (Type) ELLIS CAPLAN, MD.
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 12-21-69		24C. NAME OF CEMETERY OR CREMATORY BETH JACOB ANSHE VESHEAR
24D. LOCATION ROSEDALE, MARYLAND		25A. DATE REC'D BY HEALTH DEPT. DEC 29 1969		
25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS SOD LEVINSON & BROS. 6010 REISTERSTOWN ROAD		



# FUNERAL DIRECTOR: IMPORTANT

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S-655 69 12756		BALTIMORE CITY HEALTH DEPARTMENT <b>CERTIFICATE OF DEATH</b>		REG. NO. 69 12756	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>HARRY SHERMAN</b>		2. DATE AND HOUR OF DEATH <b>3:07 AM 12/21/69</b> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>7</b> B. COUNTY <b>2102</b>			
FULL NAME OF HOSPITAL OR INSTITUTION <b>38 University Hospital, Balto. Md.</b>		C. CITY OR TOWN <b>BALTIMORE</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER <b>1144 SARGEANT STREET #21223</b>			
5. SEX <b>MALE</b>	6. RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9-3-00</b>	9. AGE (in years lost birthday) <b>69</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SALESMAN</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>RETAIL</b>		11. BIRTHPLACE (State or foreign country) <b>BALTIMORE MARYLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>MORRIS SHERMAN</b>		14. MOTHER'S MAIDEN NAME <b>LENA SHERMAN</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>217-18-0729</b>		17. INFORMANT <b>MRS IDA SHERMAN, 6936 MILBROOK PARK DRIVE</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <b>410.91</b> (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>Cardiogenic Shock</b>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Acute myocardial infarction</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Hours - minutes</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF: <b>-</b>		(C) DUE TO, OR AS A CONSEQUENCE OF: <b>-</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>0</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>2:20 PM 12/21/69</b> to <b>3:07 PM 12/21/69</b> , that (I) <input checked="" type="checkbox"/> last saw the deceased alive on <b>12/21/69</b> and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above. (I) (We) <input checked="" type="checkbox"/> (did not) view the body after death.					
23A. SIGNATURE <b>L. F. AWAULT, M.D.</b>		23B. DATE SIGNED <b>12/21/69</b>		23C. PHYSICIAN'S NAME (Type) <b>L. F. AWAULT, M.D.</b>	
23D. ADDRESS <b>University Hospital, Balto. Md.</b>		23E. DATE REC'D BY HEALTH DEPT. <b>DEC 29 1969</b>		23F. NAME OF REGISTRAR <b>Bob E. Taylor, M.D.</b>	
23G. FUNERAL DIRECTOR <b>SOL LEVINSON &amp; BROS. 6010 REISTERSTOWN ROAD</b>		23H. ADDRESS <b>6010 REISTERSTOWN ROAD</b>		23I. DATE OF DEATH <b>12-22-69</b>	
23J. NAME OF CEMETERY or CREMATORY <b>BNAI ISRAEL, SOUTHERN AVE.</b>		23K. LOCATION <b>MARYLAND</b>		23L. DATE OF DEATH <b>12-22-69</b>	

1

THE STATE OF NEW YORK

IN SENATE

JANUARY 1, 1911

REPORT

OF THE

COMMISSIONERS

OF THE LAND OFFICE

IN RESPONSE TO A RESOLUTION

ADOPTED BY THE SENATE, APRIL 1, 1909

BY

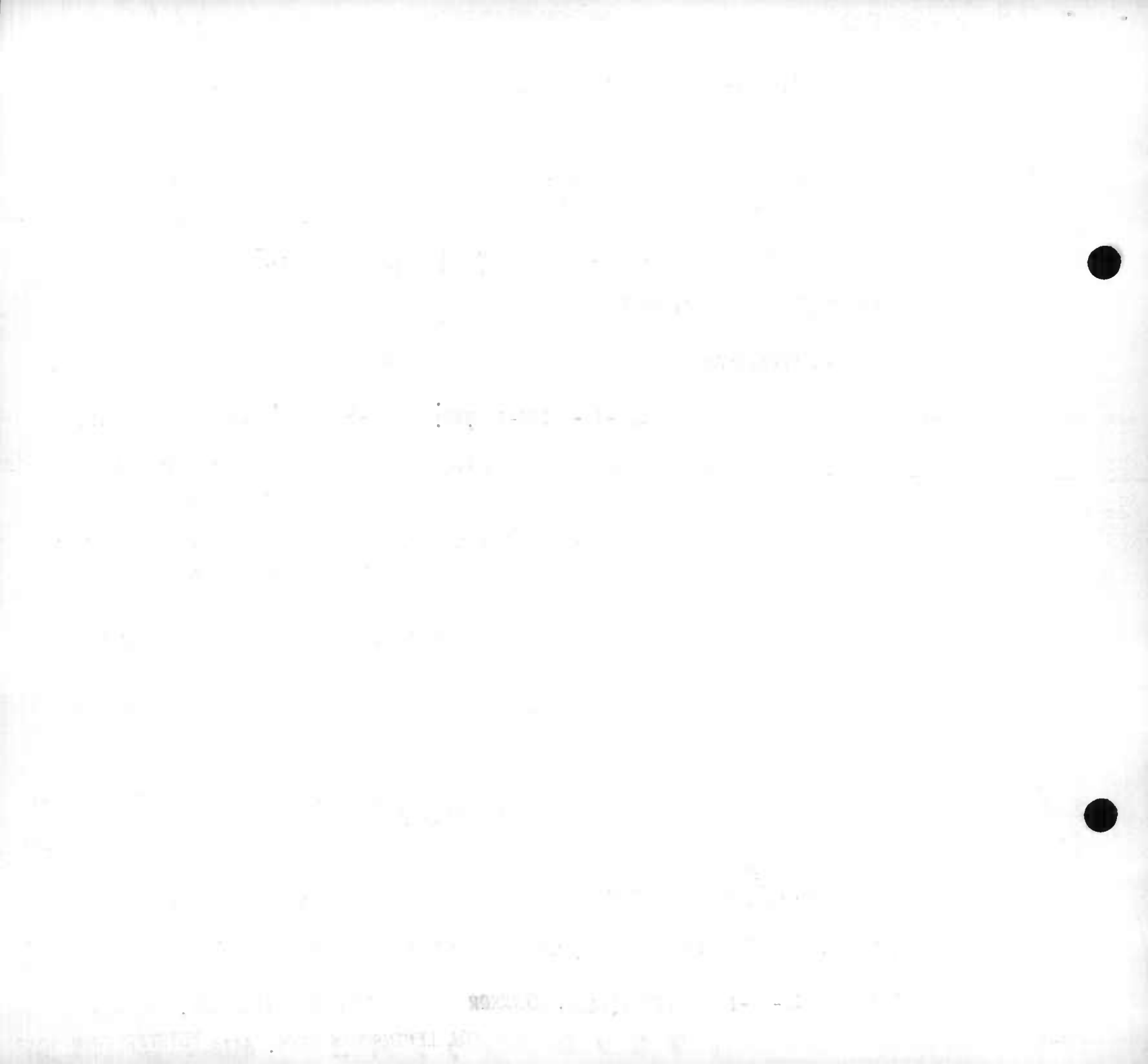
ALBANY: J. B. LEECH, STATE PRINTER, 1911

100

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

G-650		69 12757		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 69 12757	
BIRTH NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>SONYA GOREN</b>				2. DATE AND HOUR OF DEATH <b>12-20-69 7:10 P.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>42 SINAI HOSPITAL OF BALTO INC</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>2730</b>			
				C. CITY OR TOWN <b>BALTIMORE</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <b>6505 WESTERN RUN MD.</b>			
5. SEX <b>Female</b>	6. RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>1-6-92</b>	9. AGE (In years lost birthday) <b>77</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>AT HOME</b>		11. BIRTHPLACE (State or foreign country) <b>RUSSIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>ABRAHAM PECKERMAN</b>				14. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>			
15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>209-12-03777-1</b>		17. INFORMANT <b>MRS. JEANETTE BLUM</b> ADDRESS <b>6505 WESTERN RUN DRIVE #21215</b>			
18. <b>410.9 250.9</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>ACUTE MYOCARDIAL INFARCTION</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>ATERO SCLEROTIC CARDIOVASCULAR DISEASE</b>				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>ACUTE MYOCARDIAL INFARCTION</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>hours</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>DIABETES</b>				(B) DUE TO, OR AS A CONSEQUENCE OF: <b>years</b>		(C) <b>years</b>	
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>12-20-69</b> 19 <b>69</b> to <b>12-20</b> 19 <b>69</b> that (I) (we) last saw the deceased alive on <b>12-20</b> 19 <b>69</b> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Robert E. Levinson</b>				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>12-20-69</b>	
23C. PHYSICIAN'S NAME (Type) <b>ROBERT E. LEVINSON MD</b>				23D. ADDRESS <b>SINAI HOSPITAL OF BALTO</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>12-22-69</b>		24C. NAME of CEMETERY or CREMATORY <b>BETH TELLER, WINDSOR</b>		24D. LOCATION (City, town, or county) (State) <b>WINDSOR MILL ROAD, MARYLAND</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 29 1969</b>				25B. NAME OF REGISTRAR <b>Robert E. Levinson</b>			
				25C. FUNERAL DIRECTOR ADDRESS <b>SOL LEVINSON &amp; BROS. 6010 REISTERSTOWN ROAD</b>			

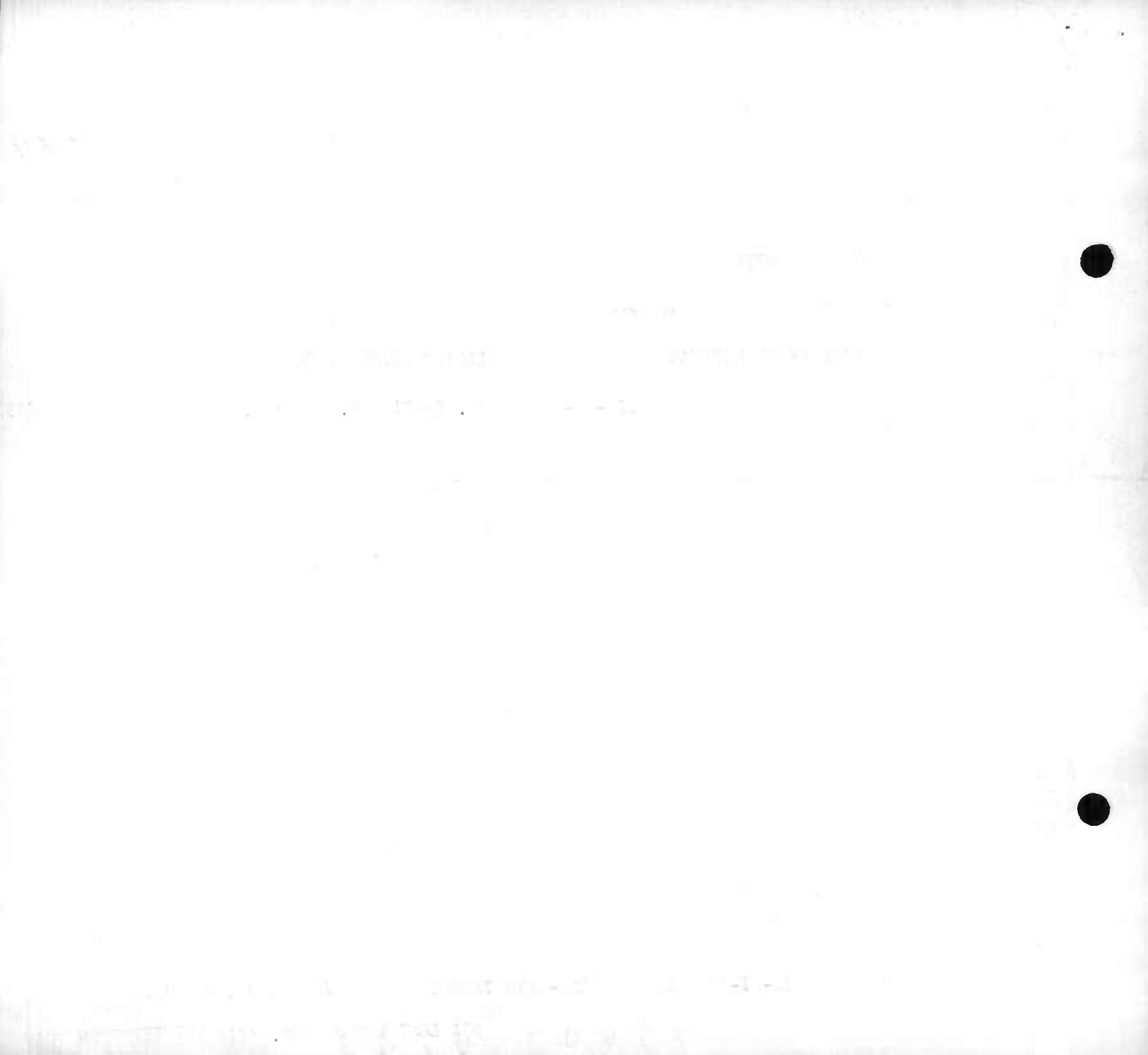




# FUNERAL DIRECTOR: IMPORTANT

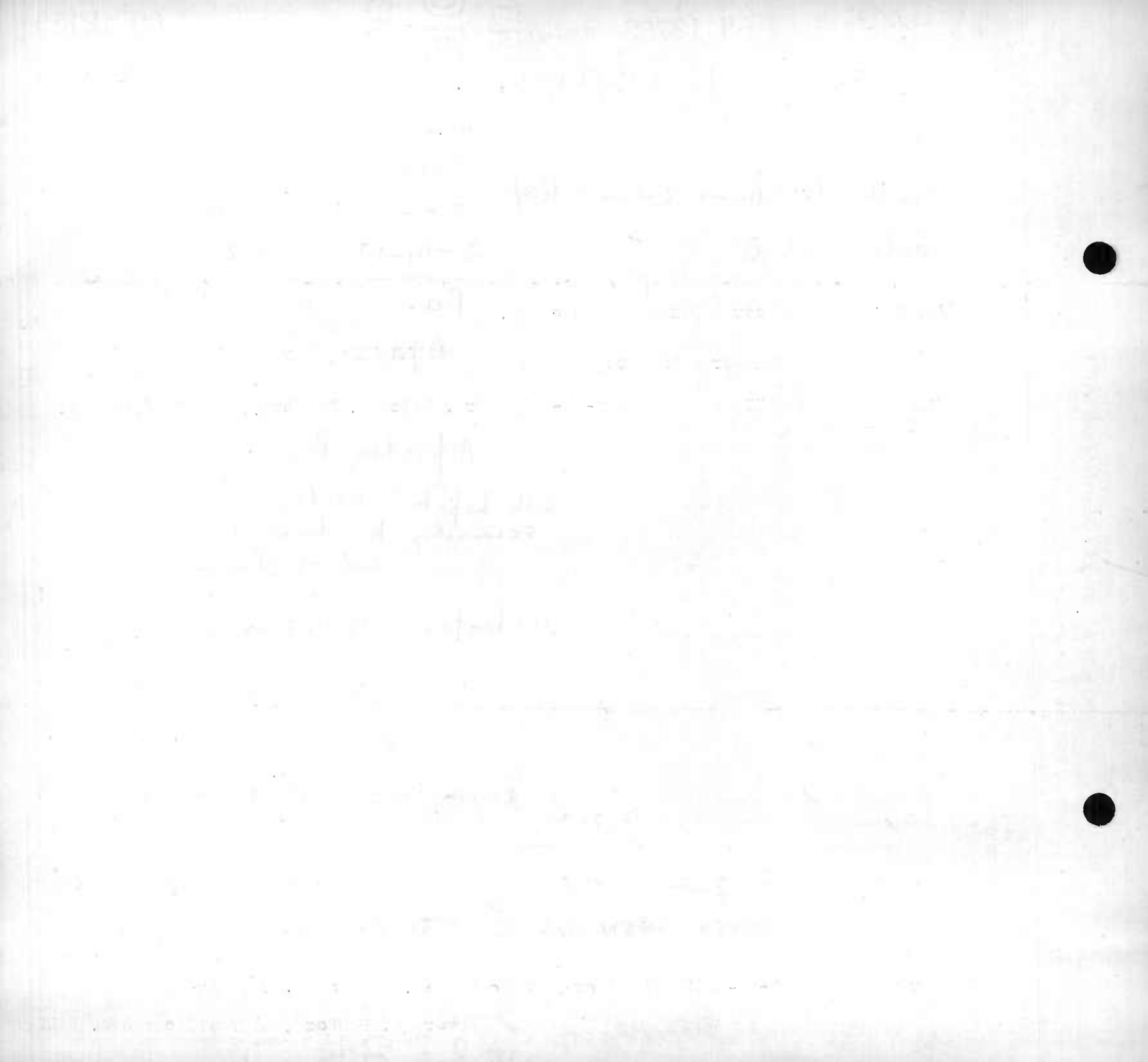
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

C-645		69 12758		BALTIMORE CITY HEALTH DEPARTMENT		X		REG. NO. 69 12758	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) <b>CURLAND, JEANETTE</b>				2. DATE AND HOUR OF DEATH <b>12-21-69 6.00AM.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>BALTO.</b> B. COUNTY <b>BALTO.</b>					
FULL NAME OF HOSPITAL OR INSTITUTION <b>42 SINAI HOSPITAL OF BALTO.</b>				C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				E. STREET AND NUMBER <b>8604 LUCERNE Rd., RANDALLSTOWN</b>					
5. SEX <b>FEMALE</b>	6. RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>1-6-15</b>	9. AGE (In years last birthday) <b>54</b>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>				10B. KIND OF BUSINESS OR INDUSTRY <b>AT HOME</b>		11. BIRTHPLACE (State or foreign country) <b>BALTIMORE</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>LATE HARRY HOFFMAN</b>				14. MOTHER'S MAIDEN NAME <b>LIVING KATIE STERN</b>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>				16. SOCIAL SECURITY NO. <b>213-38-9440</b>		17. INFORMANT <b>MR. CHARLES H. CURLAND, 8604 LUCERNE ROAD #33</b>			
18. <b>157.9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>IRREVERSIBLE SHOCK</b>				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>IRREVERSIBLE SHOCK</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>HOURS</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>ABDOMINAL CARCINOMATOSIS</b>				(B) DUE TO, OR AS A CONSEQUENCE OF: <b>10 pancreas</b>				(C) <b>MONTHS</b>	
II									
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).									
19A. DATE OF OPERATION <b>0</b>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>11-28-1969</b> to <b>12-21-1969</b> and that (I) (we) last saw the deceased alive on <b>12-21-1969</b> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <b>Atten M.D. 9184</b>						Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>12-21-69</b>	
23C. PHYSICIAN'S NAME (Type) <b>CARLOS S VALLEJO M.D. 9184</b>						23D. ADDRESS <b>SINAI HOSP. OF BALTO</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>12-22-69</b>		24C. NAME of CEMETERY or CREMATORY <b>MIKRO KODESH-BETH ISRAEL</b>			24D. LOCATION (City, town, or county) (State) <b>BOWLEYS LANE, MARYLAND</b>		
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 29 1969</b>			25B. NAME OF REGISTRAR <b>E. Taylor</b>			25C. FUNERAL DIRECTOR ADDRESS <b>SOL LEVINSON &amp; BROS. 6010 REISTERSTOWN ROAD</b>			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

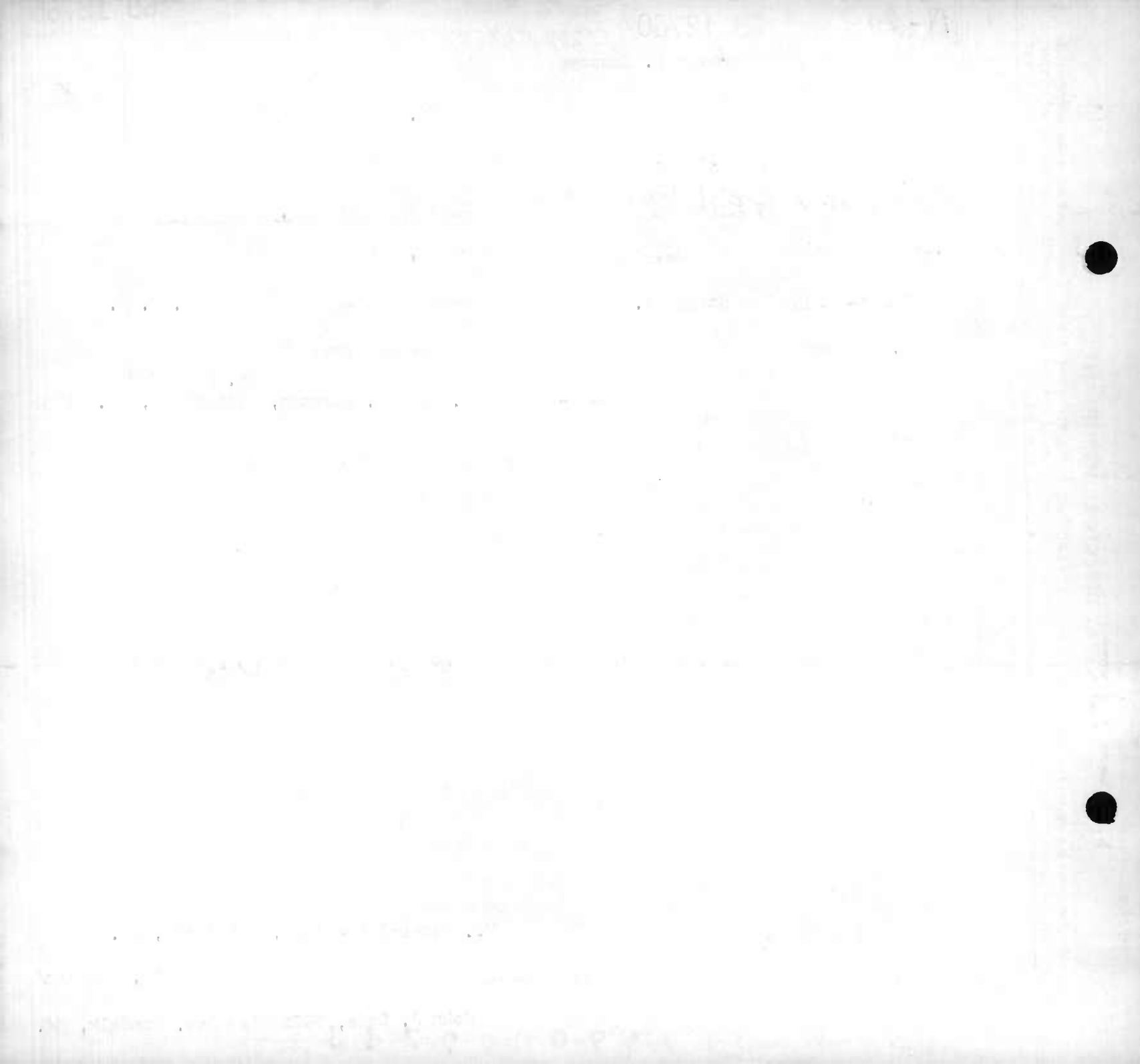
L-163		69 12759		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 69 12759	
1. NAME OF DECEASED (Type or Print) JAMES H LAFFERTY, SR.				2. DATE AND HOUR OF DEATH 12-25-69 12:30 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 43 South Baltimore General Hosp				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 2544 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 722 Pontiac Avenue			
5. SEX male	6. RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-14-17	9. AGE (In years lost birthday) 52	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) First Class Engineer		10B. KIND OF BUSINESS OR INDUSTRY Bethlehem Steel Co.		11. BIRTHPLACE (State or foreign country) Pa.		12. CITIZEN OF WHAT COUNTRY? US A	
13. FATHER'S NAME Sinkler Lafferty				14. MOTHER'S MAIDEN NAME <del>XXXXXXXX</del> Bertha (Unknown)			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes W W II		16. SOCIAL SECURITY NO. 171-07-8998		17. INFORMANT ADDRESS Mrs. Helen D. Lafferty, 722 Pontiac Ave. 21225			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 303.21 4250.9 Aspiration Pneumonia		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: with hepatic insufficiency secondary to chronic alcoholism (B) DUE TO, OR AS A CONSEQUENCE OF: alcoholism (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (H) (this hospital) attended the deceased from 3:00 P.M. 12-23-1969 to 2:30 A.M. 12-25-1969, that (H) (we) last saw the deceased alive on 2:30 A.M. 12-25-1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (H) (We) (did) (did not) view the body after death.							
23A. SIGNATURE [Signature] M.D. DEGREE				23B. DATE SIGNED 12-25-69			
23C. PHYSICIAN'S NAME (Type) HENRY CHEN M.D. DEGREE				23D. ADDRESS 3001 S. Hanover St. Balt Md			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12-29-1969		24C. NAME OF CEMETERY or CREMATORY Baltimore National Cem.		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. DEC 29 1969		25B. NAME OF REGISTRAR Robert E. [Signature]		25C. FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Ave. 21229		ADDRESS	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

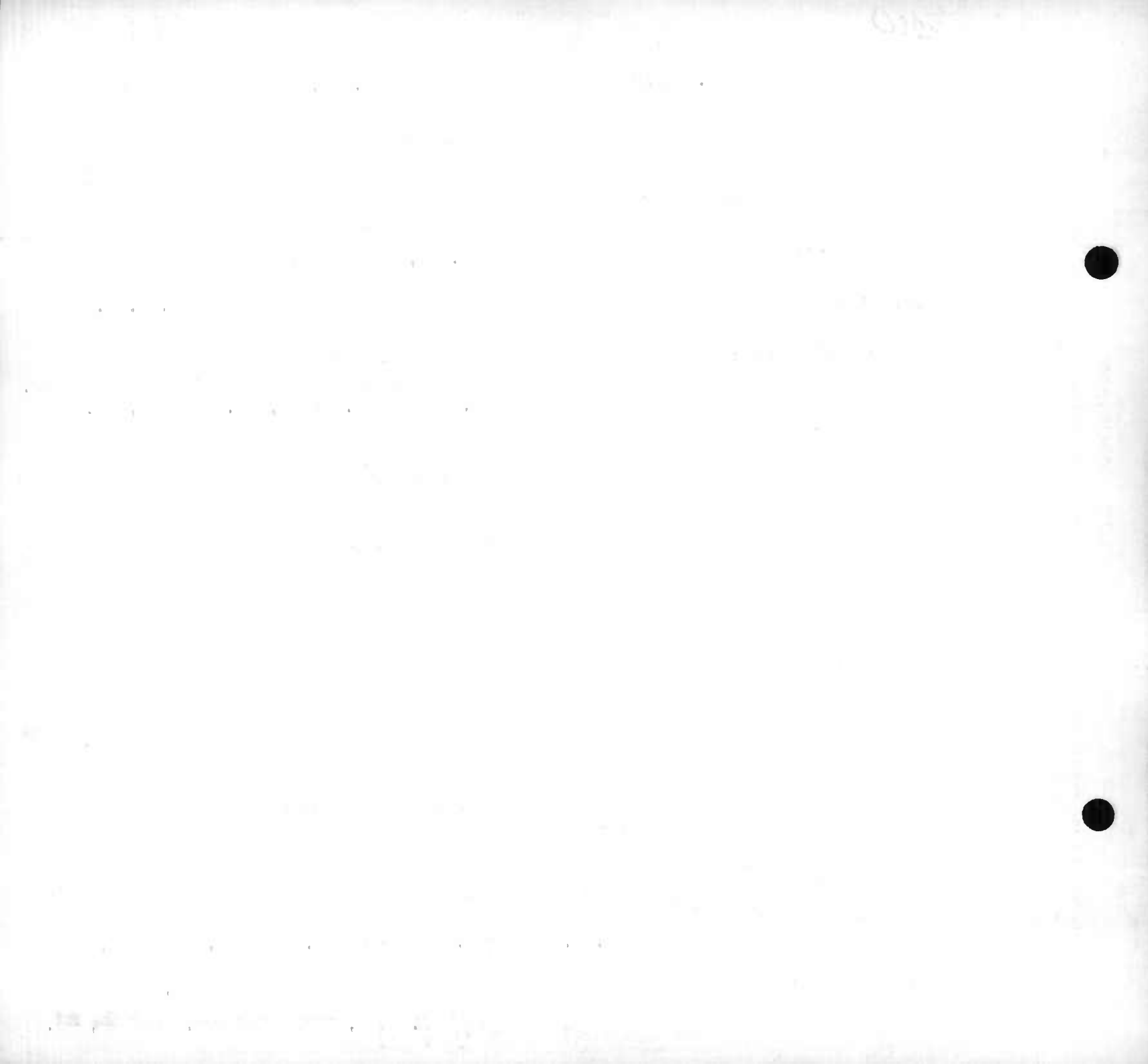
BALTIMORE CITY HEALTH DEPARTMENT		Registered No. _____	
N-250 69 12760		69 12760	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>ROBERT NEWSOME</b>	
M.E. CASE NO.		2. DATE AND HOUR OF DEATH <b>12/23/69 1945 P.M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>MARYLAND GEN. HOSPITAL</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>Baltimore</b> <b>2607 Edgemere Rd 5300</b> C. CITY OR TOWN <b>Edgemere</b> (If outside city limits, write RURAL and give township) <b>Balto. Md.</b> D. STREET ADDRESS (If rural, give location) <b>2607 Edgemere Ave.</b>	
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Married</b>	8. DATE OF BIRTH <b>April 4, 1900</b>
9. AGE (In years last birthday) <b>69</b>		10. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
11. BIRTHPLACE (State or foreign country) <b>North Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>W. Newsome</b>		14. MOTHER'S MAIDEN NAME <b>Della Howard</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>213-07-5090</b>	
17. INFORMANT <b>Mrs. Vera F. Newsome, Pittsville, Md. 21850</b>		18. ADDRESS <b>Rt. #1</b>	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Acute Myocardial Infarction</b>		INTERVAL BETWEEN ONSET AND DEATH	
20. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Arteriosclerotic Cardiovascular Disease</b>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
21A. DATE OF OPERATION <b>2</b>	21B. CONDITION FOR WHICH OPERATION WAS PERFORMED	21C. AUTOPSY? (Yes or No) <b>Yes</b>	21D. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>Yes</b>
22A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>	22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
23A. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	23B. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	23C. HOW DID INJURY OCCUR?	
24. I certify that (I) (this hospital) attended the deceased from <b>11/19/69</b> to <b>12/23/69</b> and that (I) (we) lost saw the deceased alive on <b>12/23/69</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.			
25A. SIGNATURE <b>Enrique A.</b>		25B. DATE SIGNED <b>12/23/69</b>	
26A. PHYSICIAN'S NAME (Type) <b>ENRIQUE, A.</b>		26B. ADDRESS <b>Md. General Hospital, Baltimore, Md.</b>	
27A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	27B. DATE <b>12/26/69</b>	27C. NAME OF CEMETERY or CREMATORY <b>Cedar Hill Cemetery</b>	27D. LOCATION (City, town, or county) (State) <b>Glen Burnie, Maryland</b>
28A. DATE REC'D BY HEALTH DEPT. <b>JEC 29 1969</b>	28B. NAME OF REGISTRAR <b>Robert E. Fisher, Jr.</b>	28C. FUNERAL DIRECTOR ADDRESS <b>John J. Duda, 7922 Wise Ave. Dundalk, Md.</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<div style="display: flex; justify-content: space-between;"> <span><b>BALTIMORE CITY HEALTH DEPARTMENT</b></span> <span><b>CERTIFICATE OF DEATH</b></span> </div>		REG. NO. <b>69 12761</b>	
BIRTH NO. <b>X-200</b>		1. NAME OF DECEASED (Type or Print) <b>Mildred C. Keyes</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>31 Baltimore City Hospital</b>		2. DATE AND HOUR OF DEATH <b>Dec. 23, 1969</b>	
5. SEX <b>Male</b>		6. RACE <b>White</b>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Oct. 12, 1912</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>Frederick Mandley</b>		14. MOTHER'S MAIDEN NAME <b>Emma Parrish</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>?</b>	
17. INFORMANT (Husband) <b>Mr. Charles E. Keyes, Sr.</b>		18. ADDRESS <b>8159 Park Haven Rd. Dundalk, Md.</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>412.21 ACVD</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>12 years</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>(B) Nephrosclerosis</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>15 years</b>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>II</b>			
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>No</b>	
20A. AUTOPSY? (Yes or No) <b>No</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>No</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>No</b>	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>No</b>		21D. TIME OF INJURY (APPROX.) <b>No</b>	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <b>No</b>	
22. I certify that (I) (this hospital) attended the deceased from <b>Oct 12 1969</b> to <b>Dec 23 1969</b> that (I) (we) last saw the deceased alive on <b>12-19 1969</b> and that (n) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <b>Wyman Wong</b>		23B. DATE SIGNED <b>12/24/69</b>	
23C. PHYSICIAN'S NAME (Type) <b>Wyman Wong</b>		23D. ADDRESS <b>40 S. Dundalk Ave. Dundalk, Maryland, 21222</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12/27/69</b>	
24C. NAME OF CEMETERY OR CREMATORY <b>Gardens of Faith Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 29 1969</b>		25B. NAME OF REGISTRAR <b>John E. Nabe, M.D.</b>	
25C. FUNERAL DIRECTOR <b>John E. Nabe, M.D.</b>		ADDRESS <b>7922 Wise Ave. Dundalk, Md.</b>	





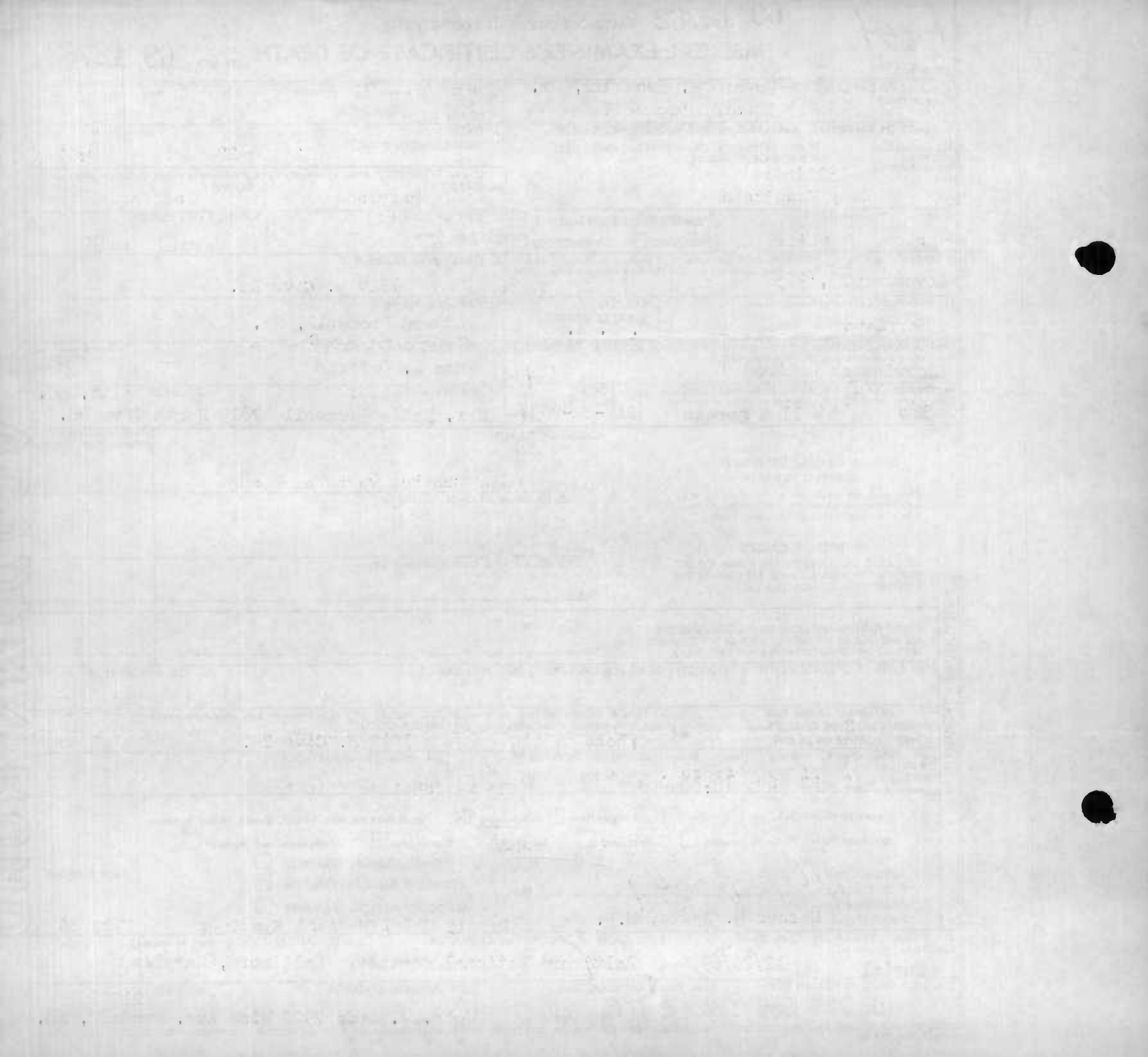
# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BALTIMORE CITY HEALTH DEPARTMENT

REG. NO. 69 12762

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Edward W. Bromwell, Jr. Edward Bromwell		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET HOSPITAL ADDRESS OR LOCATION) Baltimore City Hospitals		3. DATE PRONOUNCED DEAD Month Day Year Hour 12 22 69 10:52 P.M.	
6. SEX male		7. RACE white	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Edgemere	
9. DATE OF BIRTH November 13, 1925		10. AGE (In years last birthday) 44	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Serviceman Retired		15. MOTHER'S MAIDEN NAME Edna L. Daffron	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes WW II & Korean		17. SOCIAL SECURITY NO. 219-12-7634	
18. INFORMANT Mrs. Katie Bromwell		ADDRESS Balto. Md. 7819 North Cove Rd.	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) home	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? 7819 N. Cove Rd. 5300		22F. HOW DID INJURY OCCUR? shot self in head	
22D. TIME (Month) (Day) (Year) (Hour) (Approx.) 12 22 69 10:00pm		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Werner U. Spitz, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> Deputy Chief Medical Examiner 12/23/69	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/26/69	
24C. NAME OF CEMETERY OR CREMATORY Baltimore National Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. DEC 29 1969		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.	
25C. FUNERAL DIRECTOR John J. Duda		ADDRESS 21222 7922 Wise Ave. Dundalk, Md.	



T-625

69 12763

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 69 12763

1. NAME OF DECEASED (Type or Print) MORRIS TOURKIN		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year December 24, 1969		Hour M.
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION South Baltimore Hospital (DOA)		3. DATE PRONOUNCED DEAD Month Day Year December 24, 1969		Hour 5:10 P. M.
6. SEX Male		7. RACE White	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH Nov 19, 1913		10. AGE (In years last birthday) 56	11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Otto		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) C. P. A.
15. MOTHER'S MAIDEN NAME Bertha		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes WWII		17. SOCIAL SECURITY NO.
18. INFORMANT Mrs Ruth Tourkin		ADDRESS Same		
19. CAUSE OF DEATH 412.4 Arteriosclerotic cardiovascular disease		DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
20. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		
(B) DUE TO, OR AS A CONSEQUENCE OF:		(C) DUE TO, OR AS A CONSEQUENCE OF:		
21. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				
22A. DATE OF OPERATION		22B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) Yes
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>				
ACTUAL SIGNATURE Charles S. Springate, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED December 25, 1969
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		
		ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/26/69		24C. NAME of CEMETERY or CREMATORY Oheb Shalom
24D. LOCATION (City, town, or county) (State) Reisterstown Md		25A. DATE REC'D BY HEALTH DEPT. DEC 29 1969		25B. NAME OF REGISTRAR Robert E. Taylor
25C. FUNERAL DIRECTOR Sylvan Levinson		25D. ADDRESS 9610 Reisterstown Rd		

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R-322		69 12764		BALTIMORE CITY HEALTH DEPARTMENT		69 12764	
BIRTH NO.		RATAJCZAK		CERTIFICATE OF DEATH		REG. NO.	
1. NAME OF DECEASED (Type or Print Name) <del>ADAM</del> ADAM				2. DATE AND HOUR OF DEATH 12/23/69 1 6 <sup>45</sup> P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION 31		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Baltimore City Hospitals 4940 Eastern Ave. Baltimore, Md. 21224		C. CITY OR TOWN Baltimore,		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX Male		6. RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1-24-16	
9. AGE (In years last birthday) 53		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Joseph Ratajczak		14. MOTHER'S MAIDEN NAME Helen Sucka		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 216-14-7659	
17. INFORMANT BCH Records: Baltimore, Md. 21224		18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 19A. DATE OF OPERATION 0 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) NO 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> 21F. HOW DID INJURY OCCUR? 22. I certify that (I) (this hospital) attended the deceased from 12/18 19 69 to 12/23 19 69 that (I) (we) last saw the deceased alive on 12/23 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. 23A. SIGNATURE Leonard Feingold, M.D. 23B. DATE SIGNED 12/23/69 23C. PHYSICIAN'S NAME (Type) LEONARD FEINGOLD, M.D. 23D. ADDRESS 4940 Eastern Ave, Baltimore, Md. 21224 24A. BURIAL CREMATION, REMOVAL (Specify) Burial 24B. DATE 12-27-69 24C. NAME OF CEMETERY OR CREMATORY St Stanislaus Cemetery 24D. LOCATION (City, town, or county) (State) Baltimore, Maryland 25A. DATE REC'D BY HEALTH DEPT. DEC 29 1969 25B. NAME OF REGISTRAR Reuben E. Valley, M.D. 25C. FUNERAL DIRECTOR WALTER DABROWSKI 25D. ADDRESS 1005 DUNDALK AVENUE					

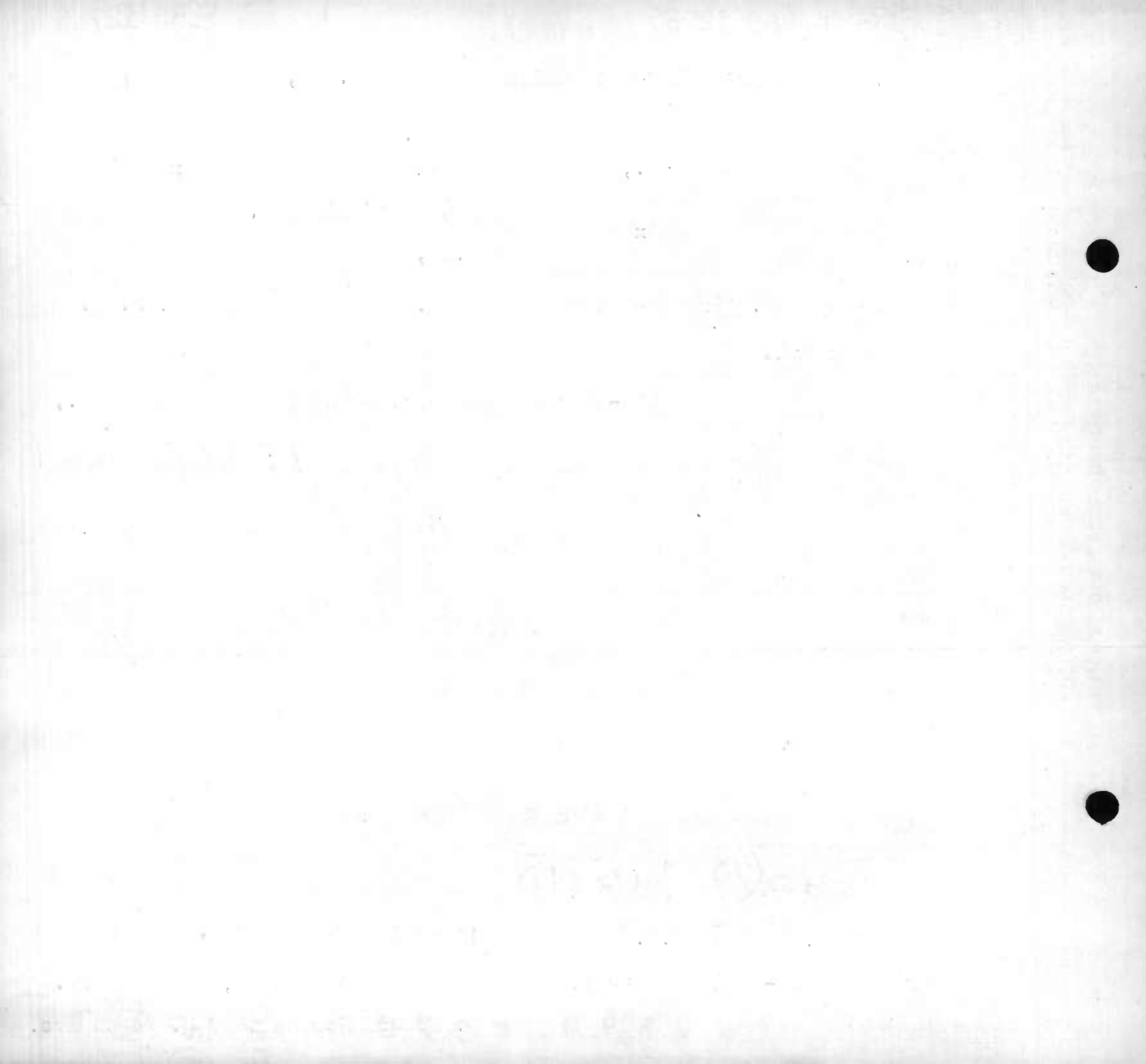




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

5-530 69 12765		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 69 12765	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Myron Ellsworth Smith		Dec. 22, 1969 4:00 P. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		A. STATE B. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		Md.		2788	
00 5249 Cordelia Ave.,		C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
		Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER			
		5249 Cordelia Ave.,			
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. Under 1 Yr. Months; Days
Male	White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	Jan. 12, 1901	68	11. Under 24 Hrs. Hours; Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Maintenance Man.		Brager-Gutman		Pa.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
Frank Smith		Emma Linns		U. S. A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
no		178-01-5890		Helen B. Smith 5249 Cordelia Ave.,	
18. 410.9 - 250.9 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		minutes	
ANTECEDENT CAUSES		(B) DUE TO, OR AS A CONSEQUENCE OF:		years,	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) DUE TO, OR AS A CONSEQUENCE OF:		years	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		D. date Miller			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
0					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from Dec. 1964 to Dec. 22, 1969, that (I) (we) last saw the deceased alive on Dec. 8, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
David I. Miller M.D.				12-23-69	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
David I. Miller M.D.				9115 reisterstown Road, Owings Mills	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		12-26-1969		Charles Baber	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
DEC 29 1969		Charles E. Taylor		G. Howard Strong 3207 W. North Ave.	

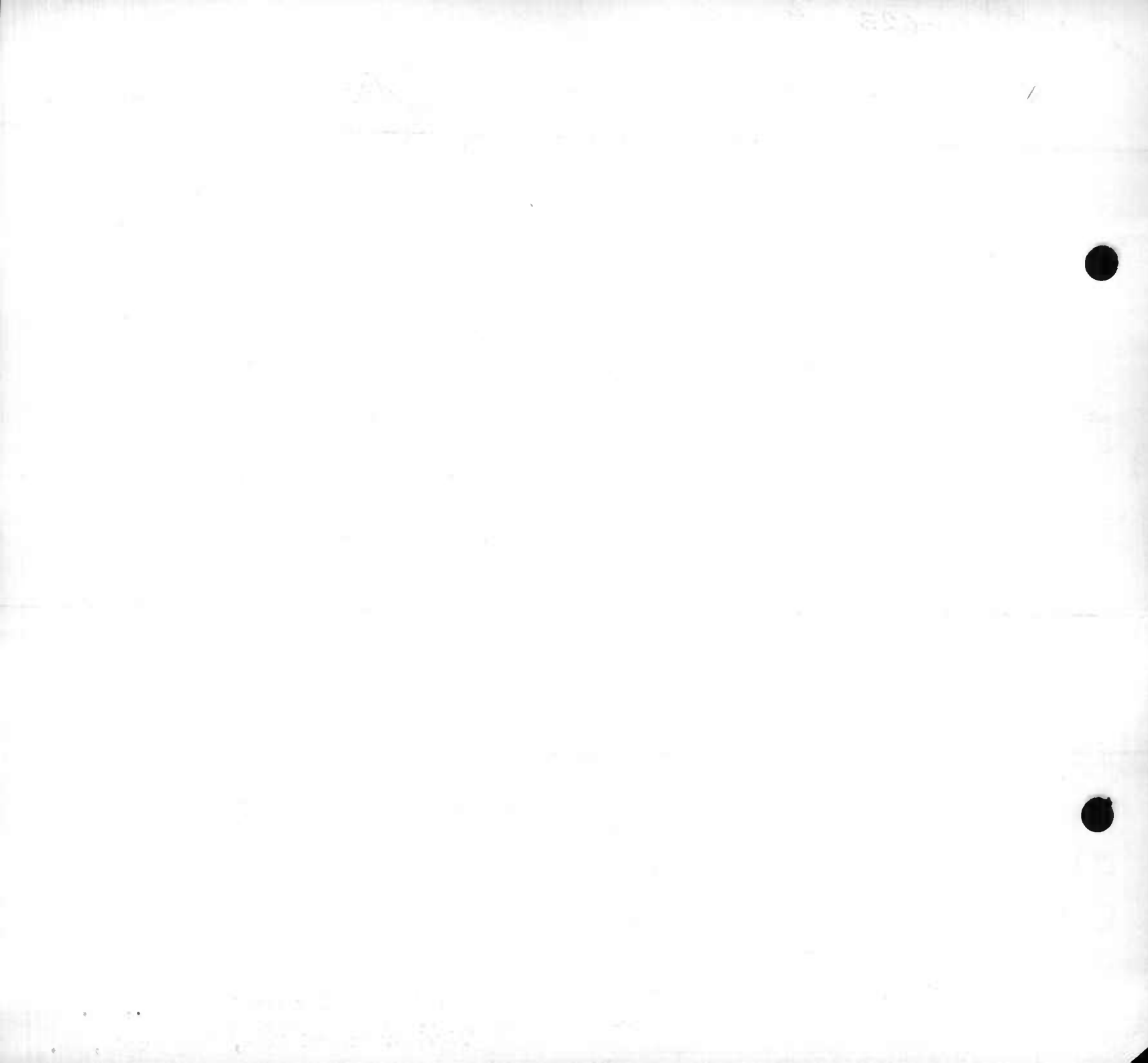




**FUNERAL DIRECTOR: IMPORTANT**

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69 12766		BALTIMORE CITY HEALTH DEPARTMENT		69 12766	
BIRTH NO. 69-24548		CERTIFICATE OF DEATH		REG. NO.	
1. NAME OF DECEASED (Type or Print) <u>Jeffery Page Barksdale</u>			2. DATE AND HOUR OF DEATH <u>Dec 25 1969 6:10 P.M.</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <u>Johns Hopkins General Hospital</u>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>1207</u>		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Johns Hopkins General Hospital</u>			C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
5. SEX <u>Male</u>			6. RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH <u>12-24-69</u>
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		9. AGE (in years last birthday) <u>11</u>
13. FATHER'S NAME <u>Thomas R Barksdale</u>			14. MOTHER'S MAIDEN NAME <u>Susan Eva Rhodes</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT <u>Father + Chart</u>
18. <u>776.1 I</u> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 19A. DATE OF OPERATION <u>0</u> 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>0</u> 20A. AUTOPSY? (Yes or No) <u>0</u> 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>0</u>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <u>Dec 24</u> 19 <u>69</u> to <u>Dec 25</u> 19 <u>69</u> that (I) (we) last saw the deceased alive on <u>Dec 25</u> 19 <u>69</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Amey &amp; Chp</u> DEGREE			23B. DATE SIGNED <u>12-25-69</u>		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>
23C. PHYSICIAN'S NAME (Type) <u>S. Crumley</u> DEGREE			23D. ADDRESS		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>29 Dec 69</u>		24C. NAME of CEMETERY or CREMATORY <u>Glen Haven Memorial Park</u>	
24D. LOCATION <u>Glen Burnie AA Co. Md.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>DEC 29 1969</u>			
25B. NAME OF REGISTRAR <u>Robert E. Talley, M.D.</u>		25C. FUNERAL DIRECTOR <u>Winkle's Funeral Home, Glen Burnie, Md.</u>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

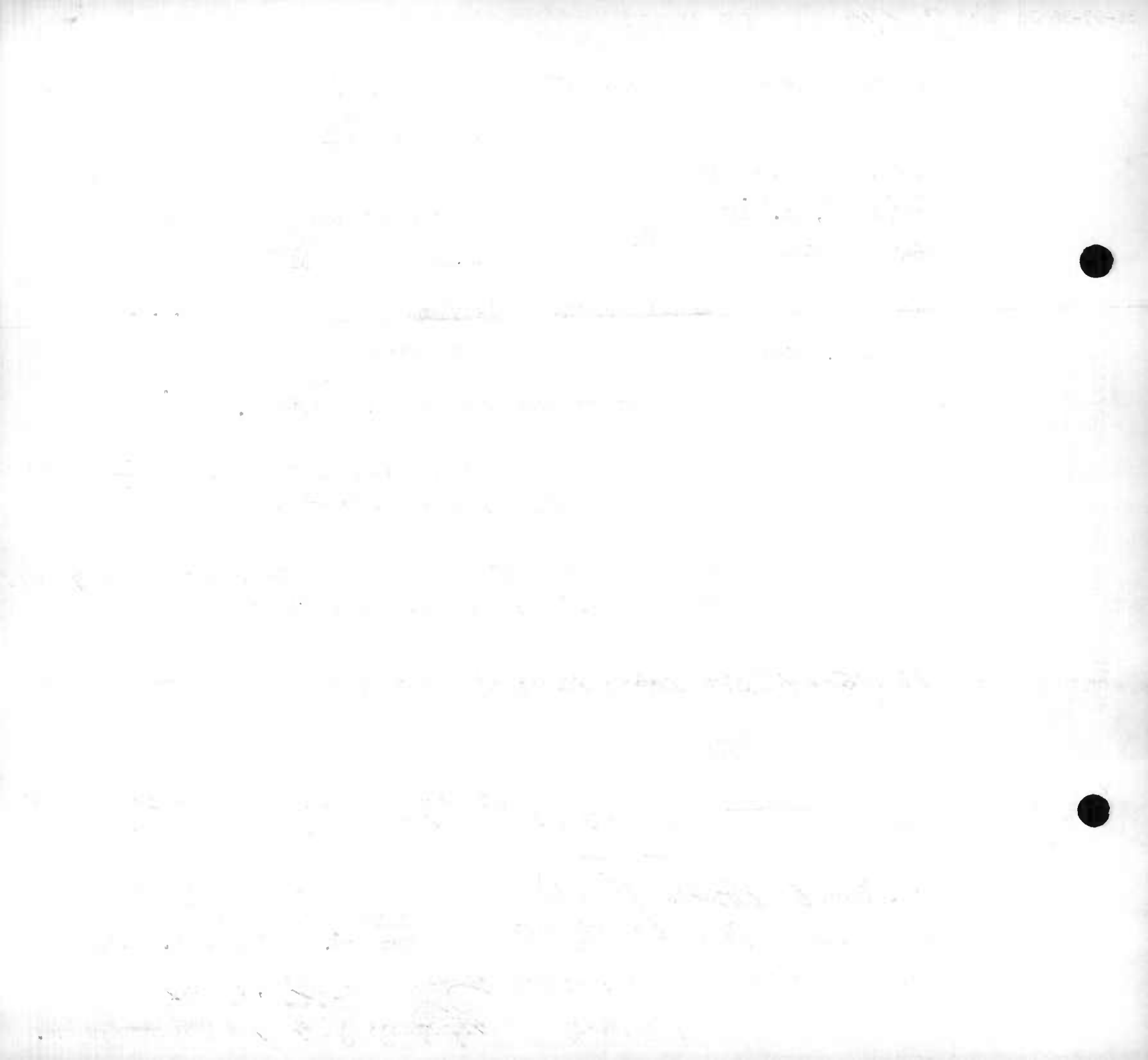
F-650		69 12767		BALTIMORE CITY HEALTH DEPARTMENT		X REG. NO.		69 12767	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>ROSALIE J. FRAME</b>				2. DATE AND HOUR OF DEATH <b>12-24-69 - 12<sup>30</sup> AM</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION <b>UNIVERSITY HOSPITAL</b>				(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE <b>MD.</b>		B. COUNTY <b>WESTMINSTER</b>	
						C. CITY OR TOWN <b>WESTMINSTER</b>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
						E. STREET AND NUMBER <b>100 CARROLL VIEW AVE</b>			
5. SEX <b>F</b>	6. RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <b>6-22-23</b>		9. AGE (in years last birthday) <b>46</b>		10. Under 1 Yr. Months: Days: Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>ASSEMBLER</b>				10B. KIND OF BUSINESS OR INDUSTRY <b>BENDIC CORP.</b>		11. BIRTHPLACE (State or foreign country) <b>MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>CLARENCE ZEPP</b>				14. MOTHER'S MAIDEN NAME <b>AMELIA MCGONIGAL</b>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>				16. SOCIAL SECURITY NO. <b>216-16-4778</b>		17. INFORMANT <b>—</b>			
18. <b>I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) IMMEDIATE CAUSE <b>METAST. CA OF BREAST-</b> DUE TO, OR AS A CONSEQUENCE OF: (B) <b>METAST. CA. OF BREAST.</b> DUE TO, OR AS A CONSEQUENCE OF: (C) <b>—</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>37 YRS</b> <b>5 YRS-</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).									
19A. DATE OF OPERATION <b>—</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>—</b>		20A. AUTOPSY? (Yes or No) <b>NO</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <b>DEC. 23</b> 19 <b>69</b> to <b>DEC 24</b> 19 <b>69</b> that (I) (we) last saw the deceased alive on <b>DEC. 24</b> 19 <b>69</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <b>Marguerite T. Moran M.D.</b>				DEGREE <b>—</b>		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>12/24/69</b>	
23C. PHYSICIAN'S NAME (Type) <b>MARGUERITE T. MORAN, M.D.</b>				DEGREE <b>—</b>		23D. ADDRESS <b>UNIVERSITY OF MD. HOSPITAL</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>12/27/69</b>		24C. NAME OF CEMETERY OR CREMATORY <b>MEADOW BRANCH</b>		24D. LOCATION (City, town, or county) (State) <b>WESTMINSTER, MD.</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 29 1969</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR <b>J. S. Thompson</b>		ADDRESS <b>Westminster, Md.</b>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

G-610		69 12768		BALTIMORE CITY HEALTH DEPARTMENT		X REG. NO.		69 12768						
BIRTH NO.					1. NAME OF DECEASED (Type or Print) <u>RITA CAROL GRAFF</u>					2. DATE AND HOUR OF DEATH <u>12-21-69</u> <u>7:15 P.M.</u>				
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD					4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u>					5. CITY OR TOWN <u>Essex 21221</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
FULL NAME OF HOSPITAL OR INSTITUTION <u>Baltimore City Hospitals</u> <u>4940 Eastern Ave.</u> <u>Baltimore, Md. #21224</u>					E. STREET AND NUMBER <u>28 Glenwood Road</u> #005									
5. SEX <u>Female</u>		6. RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3-8-37</u>		9. AGE (in years last birthday) <u>32</u>		If Under 1 Mo. <input type="checkbox"/> If Under 1 Yr. <input type="checkbox"/> If Under 24 Hrs. <input type="checkbox"/>				
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk</u>					10B. KIND OF BUSINESS OR INDUSTRY <u>Aminal Hospital</u>					11. BIRTHPLACE (State or foreign country) <u>Maryland</u>				
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>					13. FATHER'S NAME <u>John W. Twigg</u>					14. MOTHER'S MAIDEN NAME <u>Marie Keller</u>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>					16. SOCIAL SECURITY NO. <u>218 34 0189</u>					17. INFORMANT <u>BCH Records: Baltimore, Maryland 21224</u>				
18. <u>453X1</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <u>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>RECURRENT PUL-</u> DUE TO, OR AS A CONSEQUENCE OF: <u>MONARY EMBOLI</u> (B) <u>DEEP VENOUS THROMBOSIS</u> DUE TO, OR AS A CONSEQUENCE OF: <u>LOWER EXTREM.</u> (C) <u>LOWER EXTREM.</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 WKS.</u>				
19A. DATE OF OPERATION <u>12-16-69</u>					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>RECURRENT PULMONARY</u>					20A. AUTOPSY? (Yes or No) <u>NO</u>				
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>					21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)					21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				
21F. HOW DID INJURY OCCUR?					22. I certify that (I) (this hospital) attended the deceased from <u>12-14</u> 19 <u>69</u> to <u>12-21</u> 19 <u>69</u> that (I) (we) last saw the deceased alive on <u>12-21</u> 19 <u>69</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <u>William E. Powers Jr. MD</u>					23B. DATE SIGNED <u>12-21-69</u>					23C. PHYSICIAN'S NAME (Type) <u>WILLIAM E. POWERS JR. MD</u>				
23D. ADDRESS <u>Baltimore City Hospitals</u> <u>4940 Eastern Ave. Baltimore, Md. 21224</u>					24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>					24B. DATE <u>12/26/69</u>				
24C. NAME OF CEMETERY OR CREMATORY <u>Gardens of Faith Cemetery</u>					24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>					25A. DATE REC'D BY HEALTH DEPT. <u>DEC 29 1969</u>				
25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>					25C. FUNERAL DIRECTOR <u>Trzadzinski Funeral Home</u>					25D. ADDRESS <u>1407 Eastern Ave.</u>				



Medical Examiner contacted by Dr. Gary Larkin  
The body of William James Leonard  
DR. GREGORY FROM M.E. OFFICE RELEASED  
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

L-563		69 12769		BALTIMORE CITY HEALTH DEPARTMENT		69 12769					
CERTIFICATE OF DEATH						REG. NO.					
BIRTH NO.				1. NAME OF DECEASED (Type or Print) William James Leonard				2. DATE AND HOUR OF DEATH Dec. 24, 1969 3:45 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 2101							
FULL NAME OF HOSPITAL OR INSTITUTION 38 University				C. CITY OR TOWN BALTO.				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
				E. STREET AND NUMBER 932 S. PACA ST.							
5. SEX M		6. RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1/2/32		9. AGE (In years lost birthday) 37		If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer				10B. KIND OF BUSINESS OR INDUSTRY closer c.e.s.				11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Edward Leonard				14. MOTHER'S MAIDEN NAME Christina Cadden							
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no				16. SOCIAL SECURITY NO. ?		17. INFORMANT Mother		ADDRESS 932 S. PACA ST.			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) 531.0 I ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). Rheumatic Heart Disease				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Hemorrhage 2° to Gastric Ulcer (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH hrs. yrs.			
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)							
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?							
22. I certify that (I) (this hospital) attended the deceased from 12/24 19 69 to 12/24 19 69, that (I) (we) last saw the deceased alive on 12/24 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE Gary D. Wilbur						23B. DATE SIGNED 12-25-69					
23C. PHYSICIAN'S NAME (Type) DEGREE						23D. ADDRESS University Hosp.					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/29/69		24C. NAME of CEMETERY or CREMATORY Cedar Hill Camp		24D. LOCATION (City, town, or county) (State) Baltimore, Md.					
25A. DATE REC'D BY HEALTH DEPT. DEC 29 1969		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR John J. Gowan & Son		ADDRESS 22 mt.					





This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

F-426		69 12770		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 69 12770	
BIRTH NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>SAMUEL FLEISCHOR</b>				2. DATE AND HOUR OF DEATH <b>12-24-69</b> <b>0.35 a</b> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>SINAI HOSPITAL OF BALTIMORE</b> <b>42</b>				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MD</b> <del>DE</del> CITY <b>2719</b> C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>3909 Emmart av - 15</b>			
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>7-18-96</b>	9. AGE (in years last birthday) <b>73</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED TIE</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>MANUFACTURING</b>		11. BIRTHPLACE (State or foreign country) <b>RUSSIA AUSTRIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Nathan Fleischer</b>				14. MOTHER'S MAIDEN NAME <b>Amelia Laupel</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no, unknown) (If yes, give war or dates of service) <b>No.</b>		16. SOCIAL SECURITY NO. <b>816-28-9881</b>		17. INFORMANT <b>Reuben Pierce</b>		ADDRESS <b>3818 Fordgate #15</b>	
18. <b>410.9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>Myocardial infarction</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>ASCVD</b> <b>BPH - TUR</b> <b>Sudden Cardiac Arrest.</b>				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Myocardial infarction</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 hrs.</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION <b>12-22-69</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>BPH. TUR</b>		20A. AUTOPSY? (Yes or No) <b>NO</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>12-19</b> 19 <b>69</b> to <b>12-24</b> - 19 <b>69</b> that (I) (we) last saw the deceased alive on <b>12-24</b> 19 <b>69</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Luis E. Renjel M.D.</b>				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>12-24-69</b>	
23C. PHYSICIAN'S NAME (Typo) <b>LUIS E. RENJEL M.D.</b>		23D. ADDRESS <b>SINAI HOSPITAL</b>					
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12-26-69</b>		24C. NAME OF CEMETERY or CREMATORY <b>Hebrew Young Men</b>		24D. LOCATION (City, town, or county) (State) <b>Windsor Mill Rd. Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 29 1969</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor, M.D.</b>		25C. FUNERAL DIRECTOR <b>Bro. Rosten</b> <b>6010 Rosten Rd.</b>			

2000-01-01 to 2000-01-01

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2000-01-01 to 2000-01-01

2000-01-01 to 2000-01-01

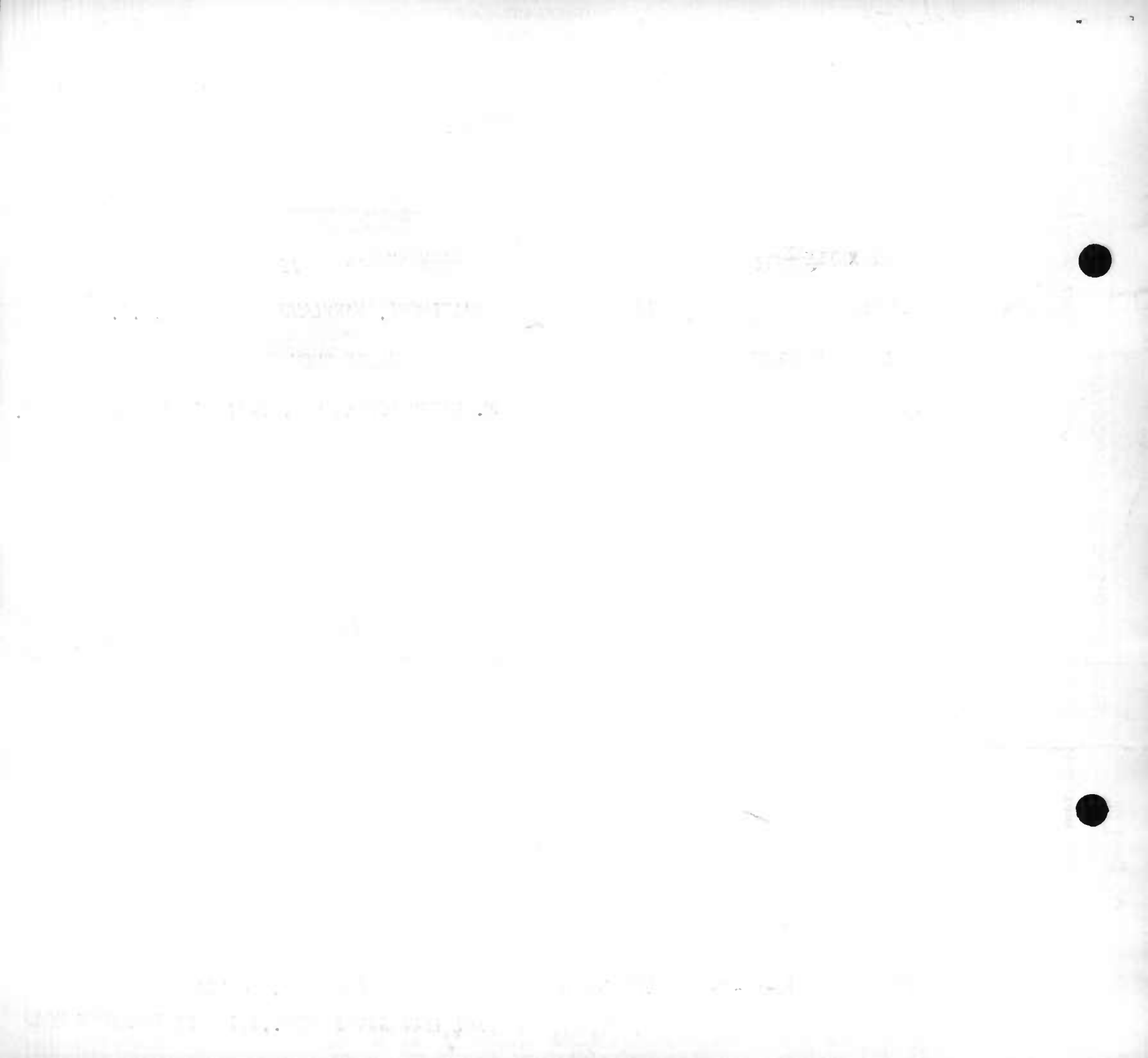
2000-01-01 to 2000-01-01

2000-01-01 to 2000-01-01

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="font-size: 1.2em;">69 12771</span>
<b>BIRTH NO.</b> <b>1. NAME OF DECEASED</b> (Type or Print) <span style="font-size: 1.2em;">HOFFENBERG WILLIAM</span>		<b>2. DATE AND HOUR OF DEATH</b> <span style="font-size: 1.2em;">12-24-69 3 P.M.</span>		
<b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b>  <b>FULL NAME OF HOSPITAL OR INSTITUTION</b> (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <span style="font-size: 1.2em;">42 SINAI HOSP BALTO MD</span>		<b>4. USUAL RESIDENCE</b> (Where deceased lived. If institution: residence before admission) A. STATE <span style="font-size: 1.2em;">MD</span> B. COUNTY <span style="font-size: 1.2em;">2755</span> <b>C. CITY OR TOWN</b> <span style="font-size: 1.2em;">BALTO</span> <b>D. INSIDE CITY LIMITS?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> <b>E. STREET AND NUMBER</b> <span style="font-size: 1.2em;">2401 Cross Country</span>		
<b>5. SEX</b> <span style="font-size: 1.2em;">MALE</span>	<b>6. RACE</b> <span style="font-size: 1.2em;">WHITE</span>	<b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input checked="" type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <span style="font-size: 1.2em;">XXXXXX</span>	
<b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">LAWYER</span>		<b>10B. KIND OF BUSINESS OR INDUSTRY</b> <span style="font-size: 1.2em;">LAW</span>		<b>9. AGE</b> (In years last birthday) <span style="font-size: 1.2em;">73</span>
<b>11. BIRTHPLACE</b> (State or foreign country) <span style="font-size: 1.2em;">BALTIMORE, MARYLAND</span>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <span style="font-size: 1.2em;">U.S.A.</span>		
<b>13. FATHER'S NAME</b> <span style="font-size: 1.2em;">BEN HOFFENBERG</span>		<b>14. MOTHER'S MAIDEN NAME</b> <span style="font-size: 1.2em;">FANNIE BUCH</span>		
<b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service) <span style="font-size: 1.2em;">NO</span>		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT</b> ADDRESS <span style="font-size: 1.2em;">MR. HARRY HOFFENBERG, 2401 CROSS COUNTRY BLVD.</span>
<b>18. CAUSE OF DEATH</b>				
<div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> <b>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b>  <span style="font-size: 1.2em;">410.9 + I 250.9</span>                      (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)  <b>ANTECEDENT CAUSES</b>                      DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  <div style="text-align: center; margin-top: 10px;">II</div> <b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</b> </div> <div style="width: 35%;"> <b>(A) IMMEDIATE CAUSE</b>                      DUE TO, OR AS A CONSEQUENCE OF:  <span style="font-size: 1.2em;">MI</span>  <b>(B)</b>                      DUE TO, OR AS A CONSEQUENCE OF:  <span style="font-size: 1.2em;">ASCVD</span>  <b>(C)</b> </div> <div style="width: 5%;"> <b>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</b>  <span style="font-size: 1.2em;">2 days</span> </div> </div>				
<b>19A. DATE OF OPERATION</b> <span style="font-size: 1.2em;">0</span>				
<b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b>				
<b>20A. AUTOPSY?</b> (Yes or No)				
<b>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</b>				
<b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner)		<b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		
<b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)		<b>21D. TIME OF INJURY</b> (Month) (Day) (Year) (Hour)		
<b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		<b>21F. HOW DID INJURY OCCUR?</b>		
<b>22. I certify that (if) (this hospital) attended the deceased from</b> <span style="font-size: 1.2em;">12/23/69</span> <b>19</b> <span style="font-size: 1.2em;">69</span> <b>to</b> <span style="font-size: 1.2em;">12/24/69</span> <b>19</b> <span style="font-size: 1.2em;">69</span> <b>that (if) (we) last saw the deceased alive on</b> <span style="font-size: 1.2em;">12/24/69</span> <b>19</b> <span style="font-size: 1.2em;">69</span> <b>and that in (my) (our) opinion death occurred on the date</b> <span style="font-size: 1.2em;">12/24/69</span> <b>and hour and from the causes stated above. (If) (We) (did) (did not) view the body after death.</b>				
<b>23A. SIGNATURE</b> <span style="font-size: 1.2em;">Norman B. Rosen MD</span>				<b>23B. DATE SIGNED</b> <span style="font-size: 1.2em;">12-23-69</span>
<b>23C. PHYSICIAN'S NAME</b> (Type) <span style="font-size: 1.2em;">N. B. ROSEN, MD</span>		<b>23D. ADDRESS</b> <span style="font-size: 1.2em;">SINAI HOSP - BALTIMORE MD</span>		
<b>24A. BURIAL CREMATION, REMOVAL</b> (Specify) <span style="font-size: 1.2em;">BURIAL</span>		<b>24B. DATE</b> <span style="font-size: 1.2em;">12-26-69</span>		<b>24C. NAME of CEMETERY or CREMATORY</b> <span style="font-size: 1.2em;">BALTIMORE HEBREW</span>
<b>24D. LOCATION</b> (City, town, or county) (State) <span style="font-size: 1.2em;">BALTIMORE, MARYLAND</span>		<b>25A. DATE REC'D BY HEALTH DEPT.</b> <span style="font-size: 1.2em;">DEC 29 1969</span>		
<b>25B. NAME OF REGISTRAR</b> <span style="font-size: 1.2em;">Robert E. Taylor</span>		<b>25C. FUNERAL DIRECTOR</b> ADDRESS <span style="font-size: 1.2em;">SOL LEVINSON &amp; BROS., 6010 REISTERSTOWN ROAD</span>		



**FUNERAL DIRECTOR: IMPORTANT**

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BALTIMORE CITY HEALTH DEPARTMENT				X		REG. NO. <span style="background-color: black; color: black;">[REDACTED]</span>	
69 12772				69 12772		6. 55 P.M.	
BIRTH NO. <span style="font-size: 1.5em;">K-145</span>				<b>CERTIFICATE OF DEATH</b>			
1. NAME OF DECEASED (Type or Print) <span style="font-size: 1.2em;">KAPLAN, MAURICE L.</span>				2. DATE AND HOUR OF DEATH <span style="font-size: 1.2em;">12/25/69</span>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institutions residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <span style="font-size: 1.2em;">42 SINAI</span>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <span style="font-size: 1.2em;">HOSPITAL OF BALTIMORE</span>		A. STATE <span style="font-size: 1.2em;">MARYLAND</span>		B. COUNTY <span style="font-size: 1.2em;">BALTIMORE CO.</span>	
				C. CITY OR TOWN <span style="font-size: 1.2em;">BALTIMORE</span>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <span style="font-size: 1.2em;">6940 MARSUE DR. #15</span>			
5. SEX <span style="font-size: 1.2em;">MALE</span>	6. RACE <span style="font-size: 1.2em;">WHITE</span>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <span style="font-size: 1.2em;">8/25/1902</span>	9. AGE (in years last birthday) <span style="font-size: 1.2em;">75</span>	If Under 1 Yr. Months: Days: Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">RETAIL</span>		10B. KIND OF BUSINESS OR INDUSTRY <span style="font-size: 1.2em;">CLOTHING</span>		11. BIRTHPLACE (State or foreign country) <span style="font-size: 1.2em;">DUBOIS, PENNSYLVANIA</span>		12. CITIZEN OF WHAT COUNTRY? <span style="font-size: 1.2em;">U.S.A.</span>	
13. FATHER'S NAME <span style="font-size: 1.2em;">ABRAHAM KAPLAN</span>				14. MOTHER'S MAIDEN NAME <span style="font-size: 1.2em;">MARY ?</span>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <span style="font-size: 1.2em;">W.W. I</span>		16. SOCIAL SECURITY NO. <span style="font-size: 1.2em;">ARMY</span>		17. INFORMANT <span style="font-size: 1.2em;">MRS. ROSE KAPLAN, 6940 MARSUE DR., APT. 1 B</span>			
18. <span style="font-size: 1.5em;">412.41</span> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <span style="font-size: 1.2em;">PULMONARY EMBOL</span>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <span style="font-size: 1.2em;">PULMONARY EMBOL</span>			
				(B) <span style="font-size: 1.2em;">ATHEROSCLEROTIC CARDIOVASCULAR DISEASE</span> DUE TO, OR AS A CONSEQUENCE OF:			
				(C) _____			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				<span style="font-size: 1.2em;">CONGESTIVE HEART FAILURE</span>			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <span style="font-size: 1.2em;">11/28</span> 19 <span style="font-size: 1.2em;">69</span> to <span style="font-size: 1.2em;">12/25</span> 19 <span style="font-size: 1.2em;">69</span> that (I) (we) last saw the deceased alive on <span style="font-size: 1.2em;">12/25</span> 19 <span style="font-size: 1.2em;">69</span> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <span style="font-size: 1.2em;">[Signature] 9088 M.D.</span>				23B. DATE SIGNED <span style="font-size: 1.2em;">12/25/69</span>			
23C. PHYSICIAN'S NAME (Type) <span style="font-size: 1.2em;">Dr. NEELAM KAPOOR</span>		23D. ADDRESS <span style="font-size: 1.2em;">9088 M.D.</span>		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>			
24A. BURIAL CREMATION, REMOVAL (Specify) <span style="font-size: 1.2em;">BURIAL</span>		24B. DATE <span style="font-size: 1.2em;">12-26-69</span>		24C. NAME OF CEMETERY OR CREMATORY <span style="font-size: 1.2em;">CHIZUK AMUNO (ARLINGTON)</span>		24D. LOCATION (City, town, or county) (State) <span style="font-size: 1.2em;">BALTIMORE, MARYLAND</span>	
25A. DATE REC'D BY HEALTH DEPT. <span style="font-size: 1.2em;">DEC 29 1969</span>		25B. NAME OF REGISTRAR <span style="font-size: 1.2em;">Robert E. Taylor, R.D.</span>		25C. FUNERAL DIRECTOR <span style="font-size: 1.2em;">SOL LEVINSON &amp; BROS., 6010 REISTERSTOWN ROAD</span>		ADDRESS	

1

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VS 150-REV. 1/1/6B

Highgate Dr.



# FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <b>69 12774</b>	
BIRTH NO. <b>5-534</b>		69 12774	
1. NAME OF DECEASED (Type or Print) <b>Sandler, Louis</b>		2. DATE AND HOUR OF DEATH <b>12/26/69 10<sup>45</sup> A.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>2788</b>	
FULL NAME OF HOSPITAL OR INSTITUTION <b>Sinai Hospital Inc.</b>		C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <b>3819 W. ROGERS AVENUE</b>		<b>Baltimore, Md.</b>	
5. SEX <b>MALE</b>	6. RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>3/15/88</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED EMPLOYEE</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>SHOE MAKER</b>	
11. BIRTHPLACE (State or foreign country) <b>RUSSIA</b>		12. CITIZEN OF WHAT COUNTRY? <del>Russia</del> <b>U.S.A.</b>	
13. FATHER'S NAME <b>MAVER SANDLER</b>		14. MOTHER'S MAIDEN NAME <b>SARAH ?</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>MRS. JEANETTE FELDMAN, 4722 OLD COURT ROAD</b>		ADDRESS	
18. <b>412.4 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <b>Pulmonary Embolism</b> (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>ASCVD.</b> <b>Congestive Heart Failure</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>hrs</b> <b>Years</b> <b>Years</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			
19A. DATE OF OPERATION <b>12/23</b>	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Pulmonary Embolism</b>	20A. AUTOPSY? (Yes or No) <b>No</b>	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH? (Indify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from <b>12/23 1969</b> to <b>12/26 1969</b> that (1) (we) last saw the deceased alive on <b>12/26 1969</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <b>Carlos R. Perel</b>		23B. DATE SIGNED <b>12/26/69</b>	
23C. PHYSICIAN'S NAME (Type) <b>Carlos R. Perel</b>		23D. ADDRESS <b>Sinai Hospital</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>	24B. DATE <b>12-28-69</b>	24C. NAME OF CEMETERY OR CREMATORY <b>BETH EL MEMORIAL PARK</b>	24D. LOCATION (City, town, or county) (State) <b>RANDALLSTOWN, MARYLAND</b>
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 29 1969</b>	25B. NAME OF REGISTRAR <b>Robert E. Taylor, M.D.</b>	25C. FUNERAL DIRECTOR <b>SOL LEVINSON &amp; BROS., 6010 REISTERSTOWN ROAD</b>	

General Hospital Inc

M W

Retired

Belmonte at 1100 Spring St

X 3/12/88 21

Insured

Primary Employer

ASCD

Corporate Health Insurance

Costs A Part  
of

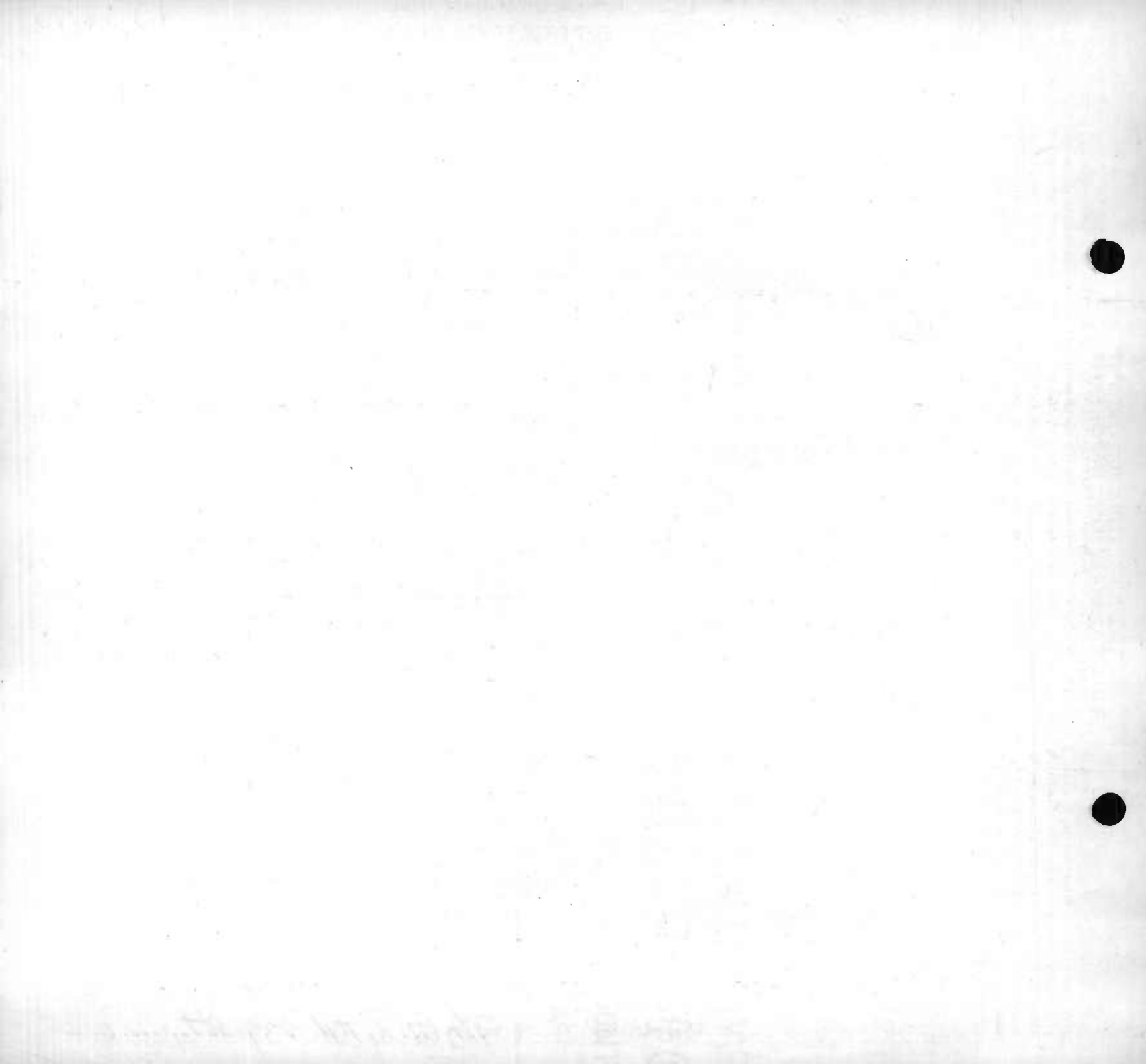
General Hospital

12/20

# FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.		69 12775	
S-334		69 12775		CERTIFICATE OF DEATH			
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
		Stadelman, Albert L.		December 23, 1969		10:00 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 33 The Johns Hopkins Hospital				A. STATE Maryland			
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 3911 5th Street			
5. SEX Male	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3/3/02	9. AGE (In years last birthday) 67	If Under 1 Yr. Months: Oays:	If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Watchmen		10B. KIND OF BUSINESS OR INDUSTRY 1st Natl Bank		11. BIRTHPLACE (State or foreign country) Md		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Unk				14. MOTHER'S MAIDEN NAME Florence			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs Dorothy M Wilson 3911-5th St 21225			
18. 412.4 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH Cardiac Insufficiency (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Aortic stenosis (B) DUE TO, OR AS A CONSEQUENCE OF: Arteriosclerotic Cardiovasc. Disease (C) Reveal Failure				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 year. years years 10 days.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from November 28, 1969 to December 23, 1969, that (I) (we) last saw the deceased alive on December 23, 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Francisco Tejada, M.D.						23B. DATE SIGNED December 23, 1969	
23C. PHYSICIAN'S NAME (Type) Francisco Tejada, M.D.				23D. ADDRESS The Johns Hopkins Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) 12/26/69		24B. DATE Burial		24C. NAME OF CEMETERY or CREMATORY Cedar Hill Cem		24D. LOCATION (City, town, or county) (State) Ritchie Hwy AA Co Md	
25A. DATE REC'D BY HEALTH DEPT. DEC 29 1969		25B. NAME OF REGISTRAR Robert E. Faber, M.D.		25C. FUNERAL DIRECTOR Mo Callahan		25D. ADDRESS 21225	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

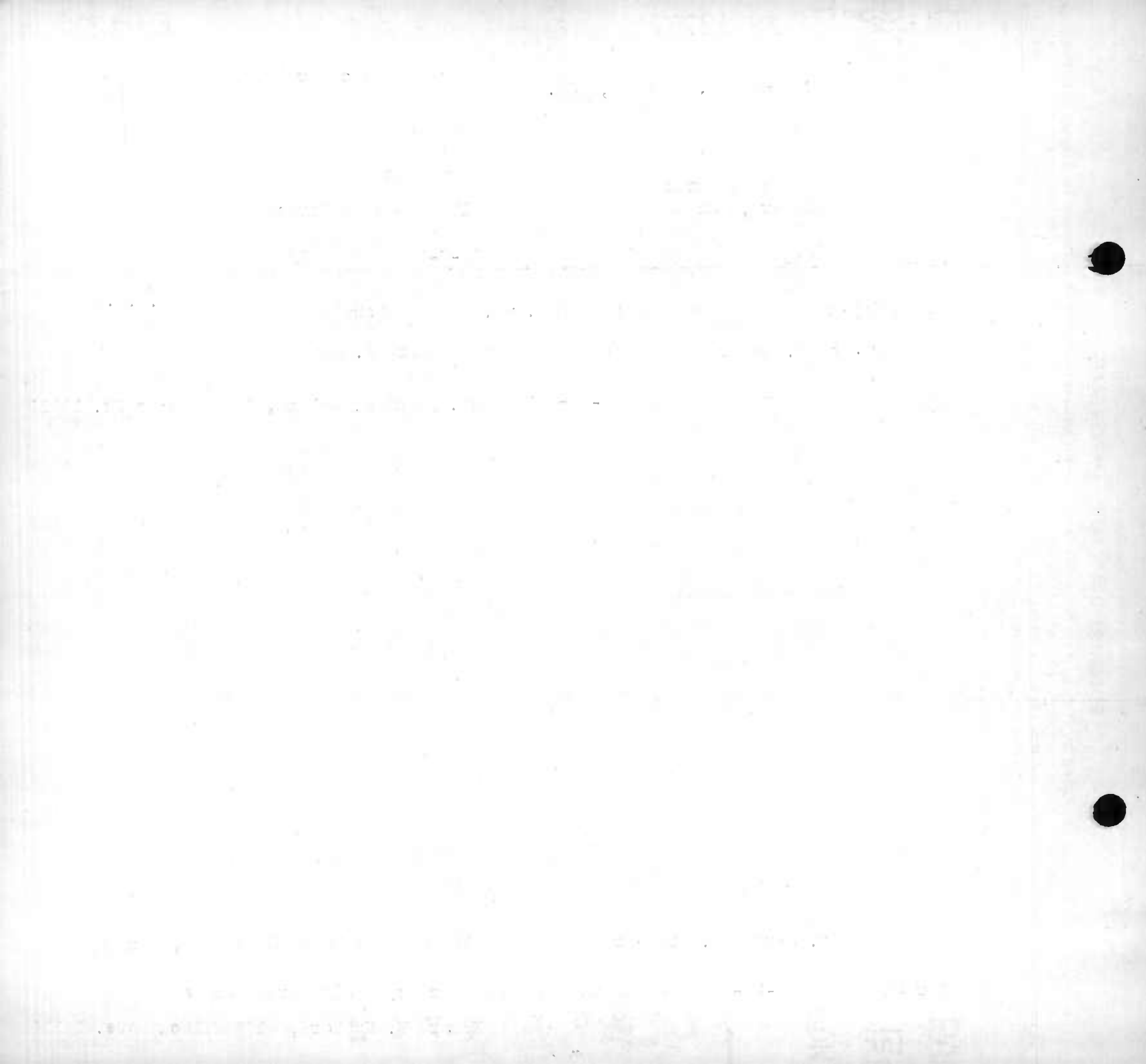
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>69 12776</u>
<b>T-512</b> <b>69 12776</b> <b>CERTIFICATE OF DEATH</b>		<b>BIRTH NO.</b> <b>1. NAME OF DECEASED</b> (Type or Print) <u>THOMPSON ROBERT</u>		
<b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b>  <b>FULL NAME OF HOSPITAL OR INSTITUTION</b> <u>SINAI HOSPITAL OF BALTIMORE</u> <u>42</u>		<b>2. DATE AND HOUR OF DEATH</b> <u>12/24/69</u> <u>11 A</u> M. <b>4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)</b> A. STATE <u>MD.</u> B. COUNTY <u>BALTIMORE</u> <b>C. CITY OR TOWN</b> <u>BALTIMORE</u> <b>D. INSIDE CITY LIMITS?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> <u>13-00</u> <b>E. STREET AND NUMBER</b> <u>3622 RESWICK #11.</u>		
<b>5. SEX</b> <u>MALE</u>	<b>6. RACE</b> <u>White</u>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>9/10/17</u>	<b>9. AGE (In years last birthday)</b> <u>52</u>
<b>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)</b> <u>EMPLOYER BOARD OF EDUCATION City of Balt.</u>		<b>10B. KIND OF BUSINESS OR INDUSTRY</b> <u>CUMBERLAND MD.</u>		
<b>11. BIRTHPLACE (State or foreign country)</b> <u>U.S.A.</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>		
<b>13. FATHER'S NAME</b> <u>Unknown</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>Unknown</u>		
<b>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)</b> <u>Yes</u> <u>WWII</u>		<b>16. SOCIAL SECURITY NO.</b> <u>213-12774</u>		
<b>17. INFORMANT</b> <u>OR KOGAN</u>		<b>ADDRESS</b> <u>SINAI HOSPITAL</u>		
<b>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		<b>CAUSE OF DEATH</b> (A) IMMEDIATE CAUSE <u>HEART FAILURE</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>BRONCHOGENIC CARCINOMA</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>BONE METASTASIS</u>		
<b>19A. DATE OF OPERATION</b> <u>10</u>		<b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b> <u>11/11/69</u>		
<b>20A. AUTOPSY? (Yes or No)</b> <input type="checkbox"/>		<b>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</b> <input type="checkbox"/>		
<b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)</b> <input type="checkbox"/>		<b>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</b> <input type="checkbox"/>		
<b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)		<b>21D. TIME OF INJURY (APPROX.)</b> (Month) (Day) (Year) (Hour)		
<b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		<b>21F. HOW DID INJURY OCCUR?</b>		
<b>22. I certify that (I) (this hospital) attended the deceased from <u>11/11/69</u> to <u>12/24</u> 19<u>69</u> that (I) (we) last saw the deceased alive on <u>12/24/69</u> 19<u>69</u> and that (in (my) (our) opinion) death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</b>				
<b>23A. SIGNATURE</b> <u>Robert E. Kogan</u>		<b>23B. DATE SIGNED</b> <u>12/24/69</u>		
<b>23C. PHYSICIAN'S NAME (Type)</b> <u>LEIB KOGAN M.D.</u>		<b>23D. ADDRESS</b> <u>SINAI HOSPITAL</u>		
<b>24A. BURIAL CREMATION, REMOVAL (Specify)</b> <u>Burial</u>		<b>24B. DATE</b> <u>12/29/69</u>		
<b>24C. NAME OF CEMETERY or CREMATORY</b> <u>Balto. National Cem.</u>		<b>24D. LOCATION (City, town, or county)</b> <u>Baltimore, Md.</u>		
<b>25A. DATE REC'D BY HEALTH DEPT.</b> <u>DEC 29 1969</u>		<b>25B. NAME OF REGISTRAR</b> <u>Robert E. Kogan, M.D.</u>		
<b>25C. FUNERAL DIRECTOR</b> <u>Ann Donovan</u>		<b>ADDRESS</b> <u>3818 Roland Ave.</u>		



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

C-165 69 12777				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 69 12777	
BIRTH NO.				1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
				THOMAS H. COBURN, SR.		December 23, 1969 9:30 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE Maryland		B. COUNTY	
00 1708 Spence Street Baltimore, Maryland 21230				C. CITY OR TOWN Baltimore,		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 1708 Spence Street			
5. SEX Male	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-8-1894	9. AGE (In years last birthday) 75	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Brick Layer		10B. KIND OF BUSINESS OR INDUSTRY Consolidated Eng. Co.		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Thomas H. Coburn				14. MOTHER'S MAIDEN NAME Mary A. Adams			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes W W I		16. SOCIAL SECURITY NO. 212-10-6048		17. INFORMANT ADDRESS Mrs. Pearl A. Coburn, 1708 Spence St. 21230			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Carcinoma of the Lung</i> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <i>September 5</i> 19 <i>69</i> to <i>December 23</i> 19 <i>69</i> , that (I) ( <del>we</del> ) lost saw the deceased alive on <i>December 23</i> 19 <i>69</i> and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>we</del> ) ( <del>did not</del> ) view the body after death.							
23A. SIGNATURE <i>Morton M. Krieger MD.</i>				23B. DATE SIGNED <i>Dec. 24, 1969</i>			
23C. PHYSICIAN'S NAME (Type) Dr. Morton M. Krieger				23D. ADDRESS 615 Hammonds Lane, Linthicum, Maryland			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12-26-69		24C. NAME OF CEMETERY or CREMATORY Baltimore National Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. DEC 29 1969		25B. NAME OF REGISTRAR <i>Robert J. ...</i>		25C. FUNERAL DIRECTOR <i>Howard H. Hubbard</i>		ADDRESS 4107 Wilkens Ave. 21229	





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

N-362		69 12778		BALTIMORE CITY HEALTH DEPARTMENT		X		REG. NO.		69 12778	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH					
		Orinthia B. Nordhouse				12-22-69 9 <sup>30</sup> A M.					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD						4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION 70 Friedlers Guest House 2449 Shirley Ave.						A. STATE Md. B. COUNTY Baltimore					
						C. CITY OR TOWN Dundalk			D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
						E. STREET AND NUMBER 6944 Broening Rd. Dundalk, Md.					
5. SEX Female		6. RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 23, 1880		9. AGE (in years last birthday) 89		11. Under 1 Yr. Months Days 11 Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10B. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Julius Horstman						14. MOTHER'S MAIDEN NAME Lydia Parks					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. None		17. INFORMANT Daughter: Dundalk, Md. 21222 Mrs. Jessis Birmingham 6944 Broening Rd.					
18. 412.3 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.						CAUSE OF DEATH Pneumonia (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cerebral Thrombosis (B) DUE TO, OR AS A CONSEQUENCE OF: arterio-sclerotic heart disease (C) None				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 days 2 years 4 years	
MEDICAL CERTIFICATION											
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).											
19A. DATE OF OPERATION 0				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from Oct 28 1969 to Dec 22 1969 that (I) (we) last saw the deceased alive on Dec 22 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE Manuel Levin M.D.								23B. DATE SIGNED 12/22/69			
23C. PHYSICIAN'S NAME (Type) MANUEL LEVIN M.D.								23D. ADDRESS 601 Park Heights Ave. Baltimore 21215			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial				24B. DATE 12/24/69		24C. NAME of CEMETERY or CREMATORY Lorraine Park Cemetery				24D. LOCATION (City, town, or county) (State) Woodlawn, Maryland	
25A. DATE REC'D BY HEALTH DEPT. DEC 29 1969				25B. NAME OF REGISTRAR Robert E. Taylor, M.D.				25C. FUNERAL DIRECTOR John U. Duda 7922 Wise Ave. Dundalk, Md. 21222			

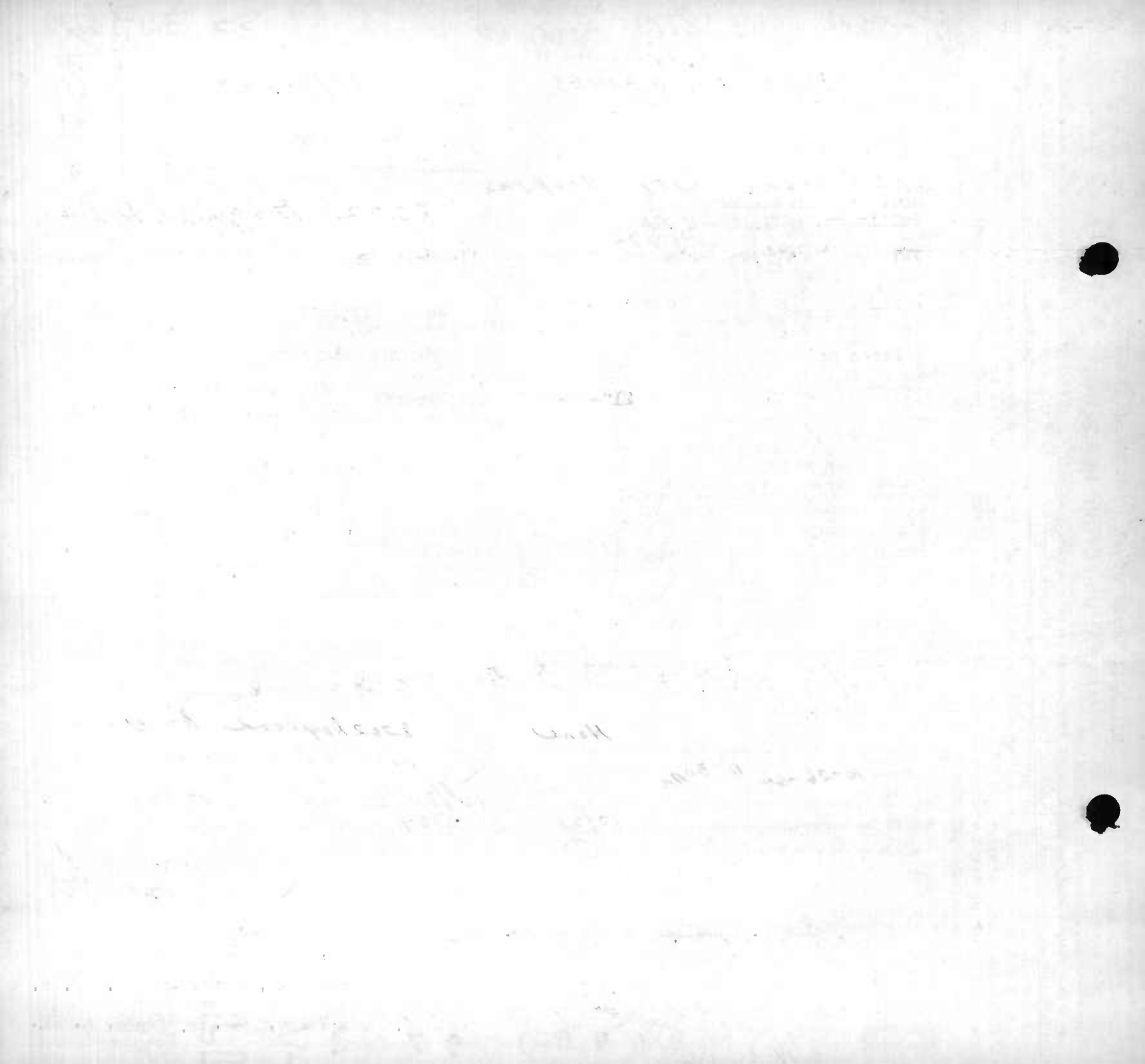


RELEASED ON APPROVAL BY MEDICAL EXAMINER

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <b>R-520</b>		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <b>69 12779</b>	
1. NAME OF DECEASED (Type or Print) <b>John I. Raines</b>		2. DATE AND HOUR OF DEATH <b>12/21/69</b> <b>1:10 P.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland, Baltimore</b> B. COUNTY <b>Dundalk</b>			
FULL NAME OF HOSPITAL OR INSTITUTION <b>BALTIMORE CITY HOSPITAL</b>		C. CITY OR TOWN <b>Dundalk</b>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
1940 Eastern Avenue <b>Baltimore, MARYLAND 21224</b>		E. STREET AND NUMBER <b>8202 Dogwood Drive</b>		21224 005	
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11-30-15</b>	9. AGE (In years lost birthday) <b>54</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Engineer Retired</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Edgewood Arsenal</b>		11. BIRTHPLACE (State or foreign country) <b>West Virginia</b>	
13. FATHER'S NAME <b>Isaac Raines</b>		14. MOTHER'S MAIDEN NAME <b>MARTHA Simpson</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes WW II</b>		16. SOCIAL SECURITY NO. <b>07-6192</b>		17. INFORMANT <b>BCH*Records</b>	
				ADDRESS <b>4940 Eastern Avenue Baltimore, Maryland 21224</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Cardiogenic Shock</b> <b>Pulmonary Emboli</b> <b>Subdural Hematoma</b>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Subdural Hematoma</b> (B) DUE TO, OR AS A CONSEQUENCE OF: <b>Brain injury as result of fall</b> (C) <b>Pulmonary Emboli Previous</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>ASCVD</b>			
19A. DATE OF OPERATION <b>10/26/69</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Subacute Subdural Hematoma</b>		20A. AUTOPSY? (Yes or No) <b>yes</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input checked="" type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Home</b>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>8202 Dogwood Drive 5300</b>	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) <b>10-26-69 4:30 AM</b>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? <b>FELL DOWN FROM LADDER</b>	
22. I certify that (I) (this hospital) attended the deceased from <b>10/26/69</b> 19 <b>69</b> to <b>12/21</b> 19 <b>69</b> , that (I) (we) last saw the deceased alive on <b>12/21</b> 19 <b>69</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) <input checked="" type="checkbox"/> (did not) view the body after death.					
23A. SIGNATURE <b>Jaime F. Casellas</b>				23B. DATE SIGNED <b>12/21/69</b>	
23C. PHYSICIAN'S NAME (Type) <b>JAIME F. CASELLAS</b>				23D. ADDRESS <b>BCH- 4940 Eastern Avenue Baltimore, Maryland 21224</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12/24/69</b>		24C. NAME OF CEMETERY or CREMATORY <b>Arbovale Cemetery</b>	
24D. LOCATION <b>Arbovale, Pocahontas Co. W.Va.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>DEC 29 1969</b>			
25B. NAME OF REGISTRAR <b>Robert E. ...</b>		25C. FUNERAL DIRECTOR <b>John J. Duda</b>		ADDRESS <b>7922 Wise Ave. Dundalk, Md. 21222</b>	



N-450 69 12780  
CERTIFICATE OF DEATH

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

NOLAN, CHARLES

2. DATE AND HOUR OF DEATH

12/21/69

10 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

BALTIMORE CITY HOSPITALS

4940 Eastern Avenue

Baltimore, Maryland 21224

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒NO ☐

E. STREET AND NUMBER

717 S. Fremont Ave. 21230 007

5. SEX  
Male6. RACE  
Negro7. MARRIED ☐ NEVER MARRIED ☐  
WIDOWED ☒ DIVORCED ☐8. DATE OF BIRTH  
10-30-099. AGE (In years  
last birthday)  
60If Under 1 Yr. If Under 24 Hrs.  
Months: Days: Hours: Min:10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Labor

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Scott Nolan

14. MOTHER'S MAIDEN NAME

Agnes Smith

15. Was Deceased Ever in U. S. Armed Forces?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

230-07-9224

17. INFORMANT

BCH-Records: 4940 Eastern Avenue  
Baltimore, Maryland 21224

ADDRESS

18.

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, osthenia, etc. It means the disease,  
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving  
rise to the above cause (A) stating the  
UNDERLYING CONDITION last.

CAUSE OF DEATH

HEAD TRAUMA

(A) IMMEDIATE CAUSE  
DUE TO, OR AS A CONSEQUENCE OF:(B) FALLING OUT OF BED  
DUE TO, OR AS A CONSEQUENCE OF:

(C) MYOTONIC DYSTROPHY

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH  
MINUTES

15 YRS.

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

YES

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. ACCIDENT WAS UNDERLYING  
OR CONTRIBUTING CAUSE OF  
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)

HOSPITAL

21C. WHERE DID INJURY OCCUR?  
(If in Baltimore City, give exact location)

D-3-W BALT. CITY HOSP. 10-03

21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

12 21 69 9:45 PM

21E. INJURY OCCURRED

While At  
Work ☐Not While  
At Work ☒21F. HOW DID INJURY OCCUR?  
PATIENT ATTEMPTED  
TO GET OUT OF BED & FELL  
STRIKING HEAD22. I certify that (A) (this hospital) attended the deceased from 7/18 19 67 to 12/21 19 69,  
that (A) (we) last saw the deceased alive on 12/21 19 69 and that in (my) (our) opinion death occurred on the date  
and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

23A. SIGNATURE

Dennis W. Bleakley MD

Attending  
Phys. ☐Med.  
Director ☐Staff  
Phys. ☒

23B. DATE SIGNED

12/21/69

23C. PHYSICIAN'S  
NAME (Type)

Dennis W. Bleakley

MD  
DEGREE

23D. ADDRESS

4940 Eastern Avenue  
BCH- Baltimore, Maryland 2122424A. BURIAL CREMATION,  
REMOVAL (Specify)

BURIAL

24B. DATE

12-27-69

24C. NAME OF CEMETERY or CREMATORY

WAYMAN GOOD HOPE

24D. LOCATION

(City, town, or county)

(State)

JONES STATION, MARYLAND

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

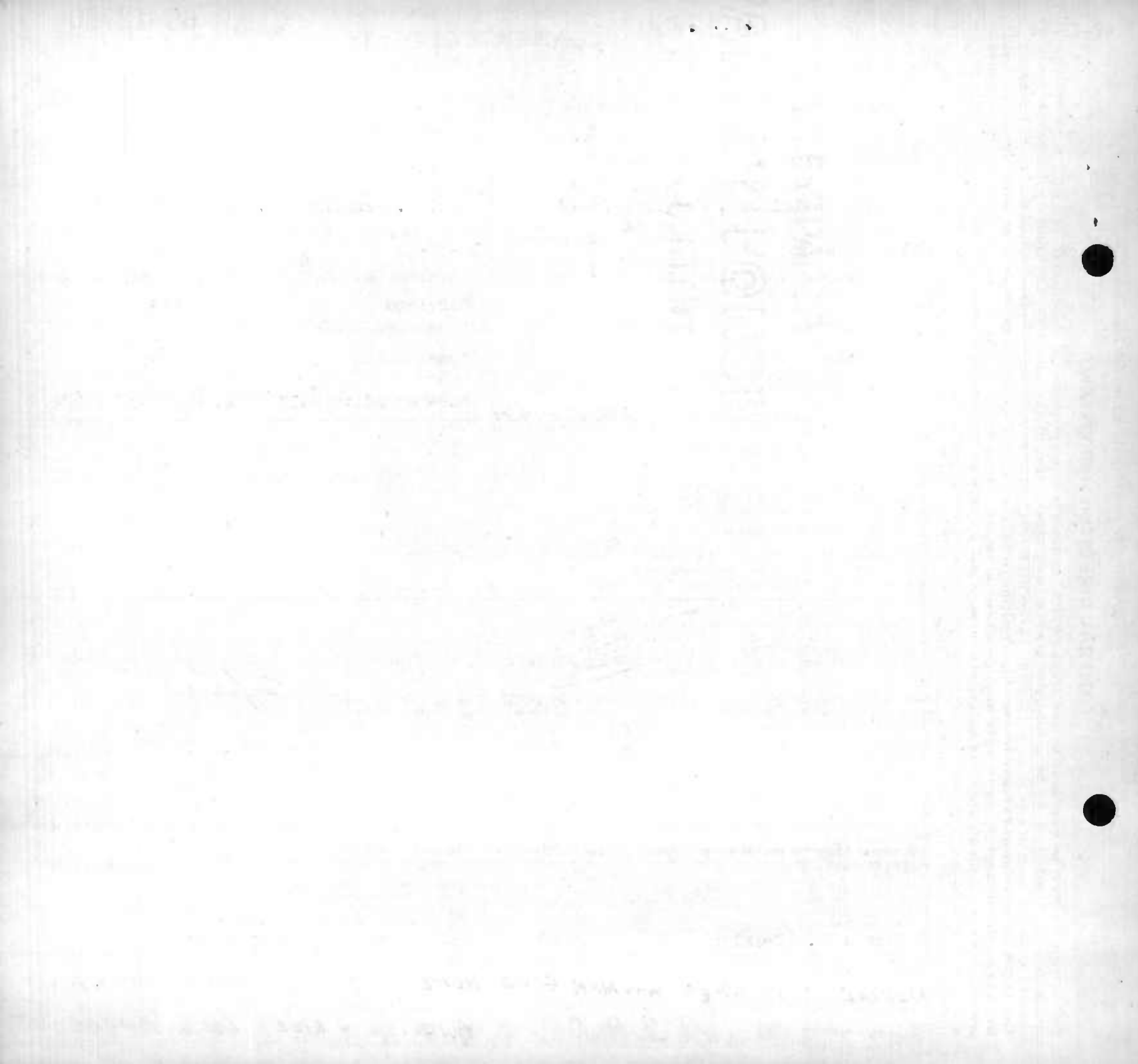
25C. FUNERAL DIRECTOR

ADDRESS

DEC 20 1969

CHARLES A. RICE 661 W. BARRE ST.

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED (Type or Print) JACK WALKER 2. DATE AND HOUR OF DEATH 12/23/69 5<sup>30</sup> A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Baltimore City Hospital  
4940 Eastern Avenue  
Baltimore, Md. 21224

A. STATE Maryland B. COUNTY 1608

C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES ☒ NO ☐

E. STREET AND NUMBER 3706 Edmondson Ave., Balto., Md. 21229

5. SEX Male 6. RACE Negro 7. MARRIED ☐ NEVER MARRIED ☐ 8. DATE OF BIRTH 7-11-1898 9. AGE (In years last birthday) 71 If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None 10B. KIND OF BUSINESS OR INDUSTRY None 11. BIRTHPLACE (State or foreign country) North Carolina 12. CITIZEN OF WHAT COUNTRY? United States

13. FATHER'S NAME Jack 14. MOTHER'S MAIDEN NAME Bessie

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) \_\_\_\_\_ 16. SOCIAL SECURITY NO. \_\_\_\_\_ 17. INFORMANT BCH Records: 4940 Eastern Avenue Baltimore, Md. 21224

18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH ADENOCARCINOMA OF PROSTATE APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 16 months

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (B) DUE TO, OR AS A CONSEQUENCE OF: (C) \_\_\_\_\_

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). Arteriosclerotic Cardiovascular Disease years

19A. DATE OF OPERATION 0 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED \_\_\_\_\_ 20A. AUTOPSY? (Yes or No) No 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? \_\_\_\_\_

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) ☐ 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) \_\_\_\_\_ 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) \_\_\_\_\_

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) \_\_\_\_\_ 21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐ 21F. HOW DID INJURY OCCUR? \_\_\_\_\_

22. I certify that ~~(if)~~ (this hospital) attended the deceased from 2/17/68 1968 to 12/23 1969 that ~~(if)~~ (we) last saw the deceased alive on 12/23 1969 and that in (my) ~~(our)~~ opinion death occurred on the date and hour and from the causes stated above. (I) ~~(We)~~ (did) (did not) view the body after death.

23A. SIGNATURE Dennis W. Bleakley MD 23B. DATE SIGNED 12/23/69

23C. PHYSICIAN'S NAME (Type) Dennis W. Bleakley, M.D. 23D. ADDRESS Baltimore City Hospital  
4940 Eastern Ave., Balto. Md. 21224

24A. BURIAL CREMATION, REMOVAL (Specify) Burial 24B. DATE 12/29/69 24C. NAME of CEMETERY or CREMATORY Baltimore National 24D. LOCATION (City, town, or county) (State) Baltimore Md

25A. DATE REC'D BY HEALTH DEPT. DEC 29 1969 25B. NAME OF REGISTRAR Robert E. Jaba, MD. 25C. FUNERAL DIRECTOR Wm. A. Rice ADDRESS 661 W. Barnard

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.





F-260 69 12782		BALTIMORE CITY HEALTH DEPARTMENT	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH		REG. NO. 69 12782	
BIRTH NO.			
1. NAME OF DECEASED (Type or Print)		2. DATE OF DEATH	
JEANETTE FISHER		Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> 10 9 69 2:30 p.m.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		3. DATE PRONOUNCED DEAD	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		Month Day Year Hour October 9, 1969 2:30 p.m.	
00 747 1/2 W. Franklin St. D.O.A.		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
		A. STATE B. COUNTY Maryland 2101	
6. SEX	7. RACE	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	C. CITY OR TOWN
Female	Negro	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	Balto.
9. DATE OF BIRTH	10. AGE (In years last birthday)	11. BIRTHPLACE (State or foreign country)	E. STREET AND NUMBER
10-26-53	16	Maryland	637 Portland St.
12. CITIZEN OF WHAT COUNTRY?	13. FATHER'S NAME	14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	15. MOTHER'S MAIDEN NAME
U.S.A.	James Fisher		Carrie Briggs
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	17. SOCIAL SECURITY NO.	18. INFORMANT	ADDRESS
no		Carrie Fisher	637 Portland St.
19. CAUSE OF DEATH			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)			
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
EPILEPSY			
(B) DUE TO, OR AS A CONSEQUENCE OF:			
(C) DUE TO, OR AS A CONSEQUENCE OF:			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
20A. DATE OF OPERATION	20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	21. AUTOPSY? (Yes or No)	
2		YES	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
22D. TIME OF INJURY (APPROX.)	22E. INJURY OCCURRED	22F. HOW DID INJURY OCCUR?	
(Month) (Day) (Year) (Hour)	WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE		CHIEF MEDICAL EXAMINER	DATE SIGNED
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER	
Isidore Mihalakis, M.D.		ASSOCIATE MEDICAL EXAMINER	
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Burial	12-24-69	Carver Mem. Park	Laural, Maryland
25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR ADDRESS	
DEC 29 1969	Robert E. Faber	Charles A. Rice 661 W. Barre St.	

SECRET

WALLEY BOINGIE

15 FEB 1960

X

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A-536

69 12783

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 69 12783

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>CLIFF ANDREWS</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> <b>December 26, 1969</b> 4:34 A. M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>48 Maryland General Hospital</b>		3. DATE PRONOUNCED DEAD Month Day Year <b>December 26, 1969</b> 4:34 A. M.	
5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>1601</b>		C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
6. SEX <b>Male</b>	7. RACE <b>Negro</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH <b>5/3/18</b>		10. AGE (In years last birthday) <b>51 58</b> If Under 1 Yr. 11 Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) <b>South Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Costodian</b>		14B. KIND OF BUSINESS OR INDUSTRY	
15. MOTHER'S MAIDEN NAME <b>Isabelle McCleode</b>		13. FATHER'S NAME <b>Haywood Andrews</b>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>yes ww 11</b>		17. SOCIAL SECURITY NO.	
18. INFORMANT <b>Fannie Chapman</b>		ADDRESS <b>2100 Dukeland St.</b>	
19. <b>5-71-9</b>		CAUSE OF DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE <b>Dcirrhosis of liver</b> DUE TO, OR AS A CONSEQUENCE OF:	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) _____ DUE TO, OR AS A CONSEQUENCE OF:	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		(C) _____	
20A. DATE OF OPERATION <b>21</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, locality, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		21. AUTOPSY? (Yes or No) <b>(Partial) Yes</b>	
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?		23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	
ACTUAL SIGNATURE <b>Isidore Mihalakis, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12/31/69</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Baltimore National</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 29 1969</b>		25B. NAME OF REGISTRAR <b>Charles A. Rice</b>	
25C. FUNERAL DIRECTOR ADDRESS <b>661 W. Barre St.</b>			

ACADEMIC BOUND

PAGE NUMBER

YALOW COMPANY

NEW YORK

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

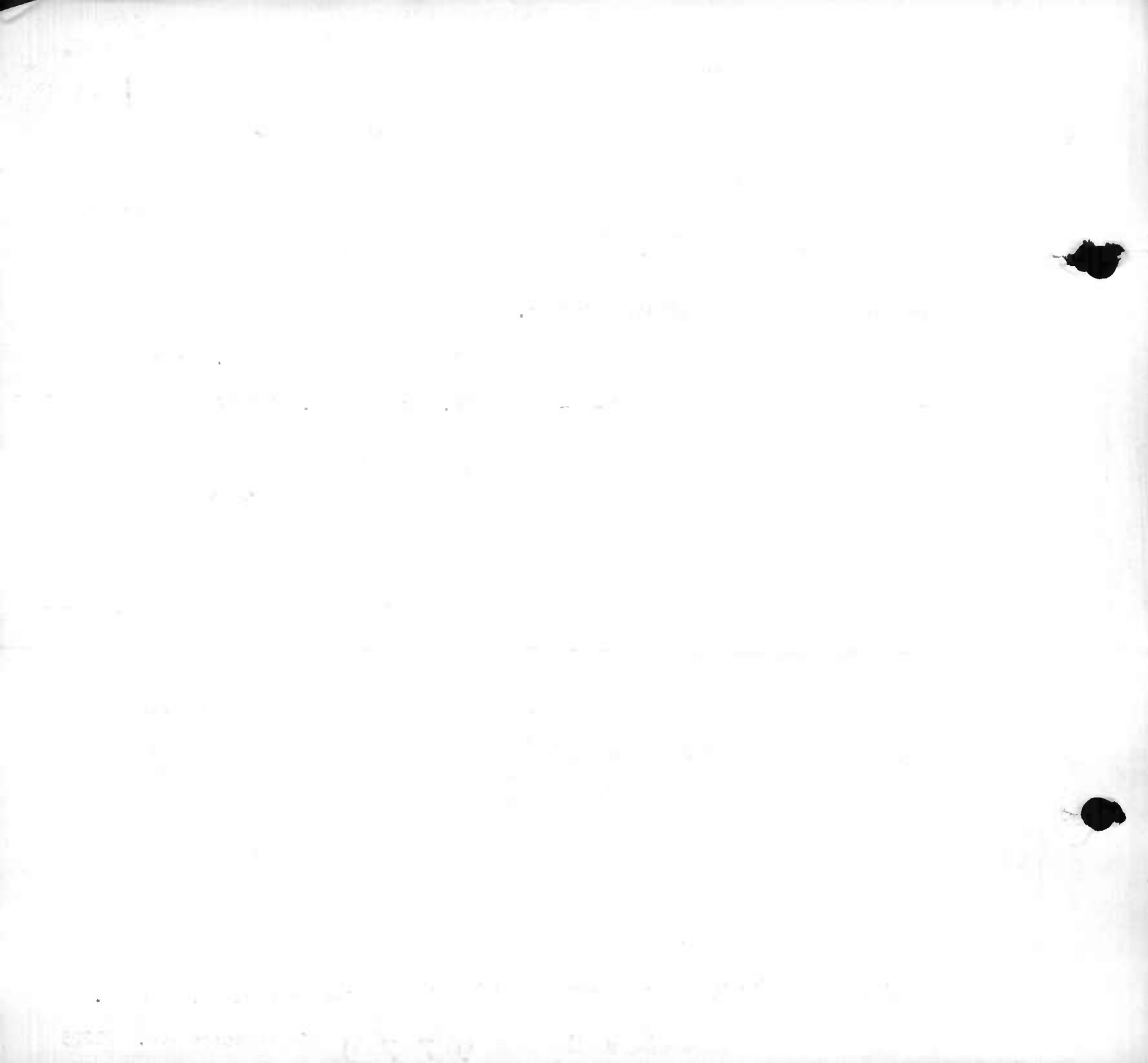
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.	69 12784
P-400 69 12784		CERTIFICATE OF DEATH			
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		SOPHIE POLEY		12-21-69 9:05 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			A. STATE B. COUNTY		
NORTH CHARLES GEN. HOSP. 2231 NORTH CHARLES ST BALT. MD 21218			MARYLAND BALTIMORE		
			C. CITY OR TOWN		D. INSIDE CITY LIMITS?
			BALTIMORE		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER		
			1 AMLEHT COURT		
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days
FEMALE	WHITE	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	12-21-97	72	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY?	
HOUSEWIFE		AT HOME		U.S.A.	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
ABRAHAM GORELIK			REVA ?		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS
NO					MR. ABRAHAM POLEY, #1 AMLEHT COURT #21208
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			CAUSE OF DEATH		
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)			CEREBRO VASCULAR DISEASE		
ANTECEDENT CAUSES			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) ARTERIO SCLEROSIS years		
			(C) Diabetes Mellitus years		
II			Urinary Tract Infection		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 12-21-1969 to 12-21-1969, that (I) (we) last saw the deceased alive on 12-21-69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE			23B. DATE SIGNED		
Gracito V. Patricio			12-21-69		
23C. PHYSICIAN'S NAME (Type)			23D. ADDRESS		
GRACITO V. PATRICIO			HCG 4		
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
BURIAL		12-22-69		CHIZUK SAMUNO	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
DEC 22 1969		Sol & Levison		SOL LEVINSON & BROS. 6010 REISTERSTOWN ROAD	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<div style="font-size: 2em; font-weight: bold;">S-200</div> <div style="font-size: 1.5em; font-weight: bold;">69 12785</div>		<div style="font-weight: bold;">BALTIMORE CITY HEALTH DEPARTMENT</div> <div style="font-weight: bold;">CERTIFICATE OF DEATH</div>		<div style="font-weight: bold;">REG. NO.</div> <div style="font-size: 1.5em; font-weight: bold;">69 12785</div>	
<div style="font-weight: bold;">BIRTH NO.</div> <div style="font-weight: bold;">1. NAME OF DECEASED</div> <div style="font-size: 0.8em;">(Type or Print)</div> <div style="font-size: 1.2em; font-weight: bold;">ANNA Sisk</div>			<div style="font-weight: bold;">2. DATE AND HOUR OF DEATH</div> <div style="font-size: 1.2em; font-weight: bold;">12-26-1969 11:40 AM</div>		
<div style="font-weight: bold;">3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</div>			<div style="font-weight: bold;">4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)</div> <div style="font-size: 0.8em;">A. STATE B. COUNTY</div> <div style="font-size: 1.2em; font-weight: bold;">MD. 2505</div>		
<div style="font-size: 0.8em;">FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)</div> <div style="font-size: 1.2em; font-weight: bold;">SOUTH BALTIMORE GENERAL HOSP. 3001 S. Harver St. Balt. Md.</div>			<div style="font-weight: bold;">C. CITY OR TOWN</div> <div style="font-size: 1.2em; font-weight: bold;">Baltimore</div>		<div style="font-weight: bold;">D. INSIDE CITY LIMITS?</div> <div style="font-size: 0.8em;">YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></div>
<div style="font-weight: bold;">5. SEX</div> <div style="font-size: 1.2em; font-weight: bold;">Female</div>			<div style="font-weight: bold;">6. RACE</div> <div style="font-size: 1.2em; font-weight: bold;">White</div>		<div style="font-weight: bold;">7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/></div>
<div style="font-weight: bold;">10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)</div> <div style="font-size: 1.2em; font-weight: bold;">Presser</div>			<div style="font-weight: bold;">10B. KIND OF BUSINESS OR INDUSTRY</div> <div style="font-size: 1.2em; font-weight: bold;">Marlboro Shirt Co.</div>		<div style="font-weight: bold;">8. DATE OF BIRTH</div> <div style="font-size: 1.2em; font-weight: bold;">7/18/93</div>
<div style="font-weight: bold;">13. FATHER'S NAME</div> <div style="font-size: 1.2em; font-weight: bold;">William Fant</div>			<div style="font-weight: bold;">14. MOTHER'S MAIDEN NAME</div> <div style="font-size: 1.2em; font-weight: bold;">XXXXXX (?) Ada R. Leake</div>		<div style="font-weight: bold;">9. AGE (In years last birthday)</div> <div style="font-size: 1.2em; font-weight: bold;">76</div>
<div style="font-weight: bold;">15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)</div> <div style="font-size: 1.2em; font-weight: bold;">No</div>			<div style="font-weight: bold;">16. SOCIAL SECURITY NO.</div> <div style="font-size: 1.2em; font-weight: bold;">220-05-1334</div>		<div style="font-weight: bold;">11. BIRTHPLACE (State or foreign country)</div> <div style="font-size: 1.2em; font-weight: bold;">Va.</div>
<div style="font-weight: bold;">17. INFORMANT</div> <div style="font-size: 1.2em; font-weight: bold;">Mr. Stonewall J. Sisk</div>			<div style="font-weight: bold;">ADDRESS</div> <div style="font-size: 1.2em; font-weight: bold;">740 Margate Dr 21061</div>		
<div style="font-weight: bold;">18. CAUSE OF DEATH</div> <div style="font-size: 1.2em; font-weight: bold;">412.2</div> <div style="font-weight: bold;">DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</div> <div style="font-size: 0.8em;">(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</div> <div style="font-weight: bold;">ANTECEDENT CAUSES</div> <div style="font-size: 0.8em;">DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</div> <div style="font-weight: bold;">(A) IMMEDIATE CAUSE</div> <div style="font-size: 1.2em; font-weight: bold;">cerebral hemorrhage</div> <div style="font-weight: bold;">DUE TO, OR AS A CONSEQUENCE OF:</div> <div style="font-weight: bold;">(B) Hypertension, ASCVD</div> <div style="font-weight: bold;">DUE TO, OR AS A CONSEQUENCE OF:</div> <div style="font-weight: bold;">(C)</div>					
<div style="font-weight: bold;">OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).</div> <div style="font-size: 1.2em; font-weight: bold;">II</div>					
<div style="font-weight: bold;">19A. DATE OF OPERATION</div> <div style="font-size: 1.2em; font-weight: bold;">0</div>		<div style="font-weight: bold;">19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</div>		<div style="font-weight: bold;">20A. AUTOPSY? (Yes or No)</div>	
<div style="font-weight: bold;">21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)</div>		<div style="font-weight: bold;">21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)</div>		<div style="font-weight: bold;">21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</div>	
<div style="font-weight: bold;">21D. TIME OF INJURY (APPROX.)</div> <div style="font-size: 0.8em;">(Month) (Day) (Year) (Hour)</div>		<div style="font-weight: bold;">21E. INJURY OCCURRED</div> <div style="font-size: 0.8em;">While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></div>		<div style="font-weight: bold;">21F. HOW DID INJURY OCCUR?</div>	
<div style="font-weight: bold;">22. I certify that (I) (this hospital) attended the deceased from 12-14-1969 to 12-26-1969 that (I) (we) last saw the deceased alive on 12-25-1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</div>					
<div style="font-weight: bold;">23A. SIGNATURE</div> <div style="font-size: 1.2em; font-weight: bold;">[Signature]</div>				<div style="font-weight: bold;">23B. DATE SIGNED</div> <div style="font-size: 1.2em; font-weight: bold;">12/26/69</div>	
<div style="font-weight: bold;">23C. PHYSICIAN'S NAME (Type)</div> <div style="font-size: 1.2em; font-weight: bold;">DR. CECILIA CHEN</div>				<div style="font-weight: bold;">23D. ADDRESS</div> <div style="font-size: 1.2em; font-weight: bold;">3001 S. Harver St.</div>	
<div style="font-weight: bold;">24A. BURIAL CREMATION, REMOVAL (Specify)</div> <div style="font-size: 1.2em; font-weight: bold;">Burial</div>		<div style="font-weight: bold;">24B. DATE</div> <div style="font-size: 1.2em; font-weight: bold;">12/30/69</div>		<div style="font-weight: bold;">24C. NAME OF CEMETERY OR CREMATORY</div> <div style="font-size: 1.2em; font-weight: bold;">Glen Haven Memorial Park</div>	
<div style="font-weight: bold;">24D. LOCATION</div> <div style="font-size: 1.2em; font-weight: bold;">Glen Burnie, Md. A A Co.</div>		<div style="font-weight: bold;">25A. DATE REC'D BY HEALTH DEPT.</div> <div style="font-size: 1.2em; font-weight: bold;">DEC 29 1969</div>			
<div style="font-weight: bold;">25B. NAME OF REGISTRAR</div> <div style="font-size: 1.2em; font-weight: bold;">Robert E. Taylor, Jr.</div>		<div style="font-weight: bold;">25C. FUNERAL DIRECTOR</div> <div style="font-size: 1.2em; font-weight: bold;">McGill</div>			
<div style="font-weight: bold;">25D. ADDRESS</div> <div style="font-size: 1.2em; font-weight: bold;">237 Patapsco Ave. 21225</div>					





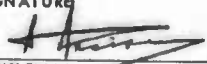
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

C-455 69 12786		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 69 12786
BIRTH NO.		2. DATE AND HOUR OF DEATH		
1. NAME OF DECEASED (Type or Print) <i>Dolores M. Clemens</i>		12/24/69 2:15 p.m.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
<div style="border: 1px solid black; padding: 5px; text-align: center;"> <b>CERTIFICATE AMENDED</b> </div> FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>Maryland General Hospital Baltimore, Md.</i>		A. STATE <i>Md.</i> B. COUNTY <i>Baltimore</i> 5300 C. CITY OR TOWN <i>Baltimore</i> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <i>9633 Dixon Ave</i>		
5. SEX <i>F</i>	6. RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>9/30/26</i>	9. AGE (in years last birthday) <i>43</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Baltimore, Md.</i>
13. FATHER'S NAME <i>Les. Meadows</i>		14. MOTHER'S MAIDEN NAME <i>Edna Cole</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>no</i>		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Jean M. Clemens same</i>
18. <i>162.1 I</i> CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		<i>Carcinoma Lung</i>		
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		
ANTECEDENT CAUSES		(B) DUE TO, OR AS A CONSEQUENCE OF:		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) _____		
II				
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION <i>01967</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Same</i>		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <i>12/24/69</i> 19 to <i>12/24/69</i> 19 that (I) (we) last saw the deceased alive on <i>12/24/69</i> 19 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <i>M. L. S. Brown</i>		23B. DATE SIGNED <i>12/24/69</i>		23C. PHYSICIAN'S NAME (Type) <i>M. L. S. Brown</i>
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>12/27/69</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Parkwood Cem.</i>
25A. DATE REC'D BY HEALTH DEPT. <i>DEC 29 1969</i>		25B. NAME OF REGISTRAR <i>Robert E. Taylor, M.D.</i>		25C. FUNERAL DIRECTOR <i>Leonard J. Ruck Inc. Balto. Md.</i>

Decedent had at. Reg. No. D7643-  
date of birth 9/30/26

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

69 12787 BALTIMORE CITY HEALTH DEPARTMENT <b>CERTIFICATE OF DEATH</b>		REG. NO. 69 12787	
BIRTH NO. 1 1. NAME OF DECEASED (Type or Print) <b>BUFFINGTON</b>		2. DATE AND HOUR OF DEATH <b>December 25, 1969 0.40' A.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>SINAI HOSPITAL OF BALTIMORE</b>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>Baltimore</b> C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER <b>Box 27 ElkrIDGE, d.</b>	
5. SEX <b>F</b>	6. RACE <b>W.</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12/13/94</b> 9. AGE (In years last birthday) <b>75</b> If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) <b>MARYLAND.</b> 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John Snider</b>		14. MOTHER'S MAIDEN NAME <b>Sallie Pickens</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. 17. INFORMANT <b>Kenneth Shipley</b> ADDRESS <b>91 Aquahart Rd. Glen Burnie</b>	
18. <b>4-12-41</b> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>MASSIVE ASCITES OF UNKNOWN AETIOLOGY.</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>ATHEROSCLEROTIC CARDIOVASCULAR DISEASE.</b>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION <b>2</b>	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) <b>YES.</b>	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I certify that (X) (this hospital) attended the deceased from <b>December 11, 1969</b> to <b>December 25, 1969</b> that (I) (we) last saw the deceased alive on <b>Dec. 25, 1969</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE 		M.D. DEGREE Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>	23B. DATE SIGNED
23C. PHYSICIAN'S NAME (Type) <b>ANDREAS A. PETASAS</b>		23D. ADDRESS <b>SINAI HOSPITAL OF BALTIMORE.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>12/29/69</b>	24C. NAME OF CEMETERY OR CREMATORY <b>Meadowridge Mem. Cem.</b>	24D. LOCATION (City, town, or county) (State) <b>Dorsey, Md.</b>
25A. DATE RECD BY HEALTH DEPT. <b>DEC 29 1969</b>		25B. NAME OF REGISTRAR <b>John E. Kelly M.D.</b>	25C. FUNERAL DIRECTOR <b>Leonard J. Ruck Inc. Balto. Md.</b> ADDRESS

0.46 29.7 29 6 1.67 1.68 A

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>69 12788</u>	
H-200		69 12788		CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		HESS; THOMAS I. SR.		December 24th 1969 15 2 AM	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION THE UNION MEMORIAL HOSPITAL		A. STATE Md.		B. COUNTY 901	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER 3827 VOLANDER ROAD BALTIMORE MD 21218			
5. SEX M	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 02-01-94	9. AGE (in years last birthday) 75	10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Accounting		10B. KIND OF BUSINESS OR INDUSTRY Railroad		11. BIRTHPLACE (State or foreign country) MARYLAND	
13. FATHER'S NAME CHARLES H. HESS		14. MOTHER'S MAIDEN NAME MARY E. GREEN		12. CITIZEN OF WHAT COUNTRY? AMERICAN	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 705-05-3032		17. INFORMANT Mrs. Sayde Hess	
				ADDRESS (Same)	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 412.31 CENTRAL VASCULAR ACCIDENT		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: ASHO & Complete A-V block			
		(B) DUE TO, OR AS A CONSEQUENCE OF:			
		(C) DUE TO, OR AS A CONSEQUENCE OF:			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from December 9th 19 69 to December 24th 19 69, that (I) (we) last saw the deceased alive on December 24th 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Tzen-chi Fan-chiang		23B. DATE SIGNED December 24th 69			
23C. PHYSICIAN'S NAME (Type) TZEN-CHI FAN-CHIANG		23D. ADDRESS Union Memorial Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/27/69		24C. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cemetery	
				24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. DEC 29 1969		25B. NAME OF REGISTRAR Robert E. Jackson, M.D.		25C. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md. 21214	
				ADDRESS	



S-520 69 12789

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 69 12789

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>ANNA J. SMYK</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year <b>December 25, 1969</b>		Hour M.
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>2900 Louise Avenue</b>		3. DATE PRONOUNCED DEAD Month Day Year <b>December 25, 1969</b>		Hour <b>8:15 A.M.</b>
6. SEX <b>Female</b>		7. RACE <b>White</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH <b>June 15, 1902</b>		10. AGE (In years lost birthday) <b>67</b>	11. BIRTHPLACE (State or foreign country) <b>Poland</b>	
12. CITIZEN OF <b>U.S.A.</b>		13. FATHER'S NAME <b>Anthony Ruszkiewicz</b>		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>
15. MOTHER'S MAIDEN NAME <b>Madeline Klimus</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		17. SOCIAL SECURITY NO.
18. INFORMANT <b>Mr Lawrence W Smyk</b>		19. ADDRESS <b>Same</b>		20. CAUSE OF DEATH <b>Carcinoma of liver with pulmonary metastases</b>
21. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>197.8</b>		22. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>II</b>		23. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).
24. DATE OF OPERATION <b>2</b>		25. CONDITION FOR WHICH OPERATION WAS PERFORMED		26. AUTOPSY? (Yes or No) <b>Yes</b>
27. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		28. PLACE OF INJURY (e.g., in or about home, farm, locality, street, office bldg., etc.)		29. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?
30. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		31. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		32. HOW DID INJURY OCCUR?
I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>				
ACTUAL EXAMINER'S NAME (Type) <b>Charles S. Springate, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>December 25, 1969</b>
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12/29/69</b>		24C. NAME OF CEMETERY or CREMATORY <b>Gardens of Faith</b>
24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>		25A. DATE REC'D BY HEALTH DEPT. <b>DEC 29 1969</b>		
25B. NAME OF REGISTRAR <b>Robert E. Sabin, M.D.</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Leonard J Ruck Inc. Baltimore, Maryland</b>		

10-11-54

MEMORANDUM FOR THE DIRECTOR

10-11-54

TO: DIRECTOR

FROM: SAC, NEW YORK

SUBJECT: [Illegible]

Re New York letter to Bureau dated 10-1-54.

Enclosed for the Bureau are two copies of a letterhead memorandum (LHM) dated 10-1-54.

The LHM is being furnished to the Bureau for its information.

Very truly yours,  
[Illegible Signature]

Enclosed for the Bureau are two copies of a letterhead memorandum (LHM) dated 10-1-54.

The LHM is being furnished to the Bureau for its information.

Very truly yours,  
[Illegible Signature]

Enclosed for the Bureau are two copies of a letterhead memorandum (LHM) dated 10-1-54.

The LHM is being furnished to the Bureau for its information.

Very truly yours,  
[Illegible Signature]

Enclosed for the Bureau are two copies of a letterhead memorandum (LHM) dated 10-1-54.

The LHM is being furnished to the Bureau for its information.

Very truly yours,  
[Illegible Signature]

Enclosed for the Bureau are two copies of a letterhead memorandum (LHM) dated 10-1-54.

The LHM is being furnished to the Bureau for its information.

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Very truly yours,  
[Illegible Signature]

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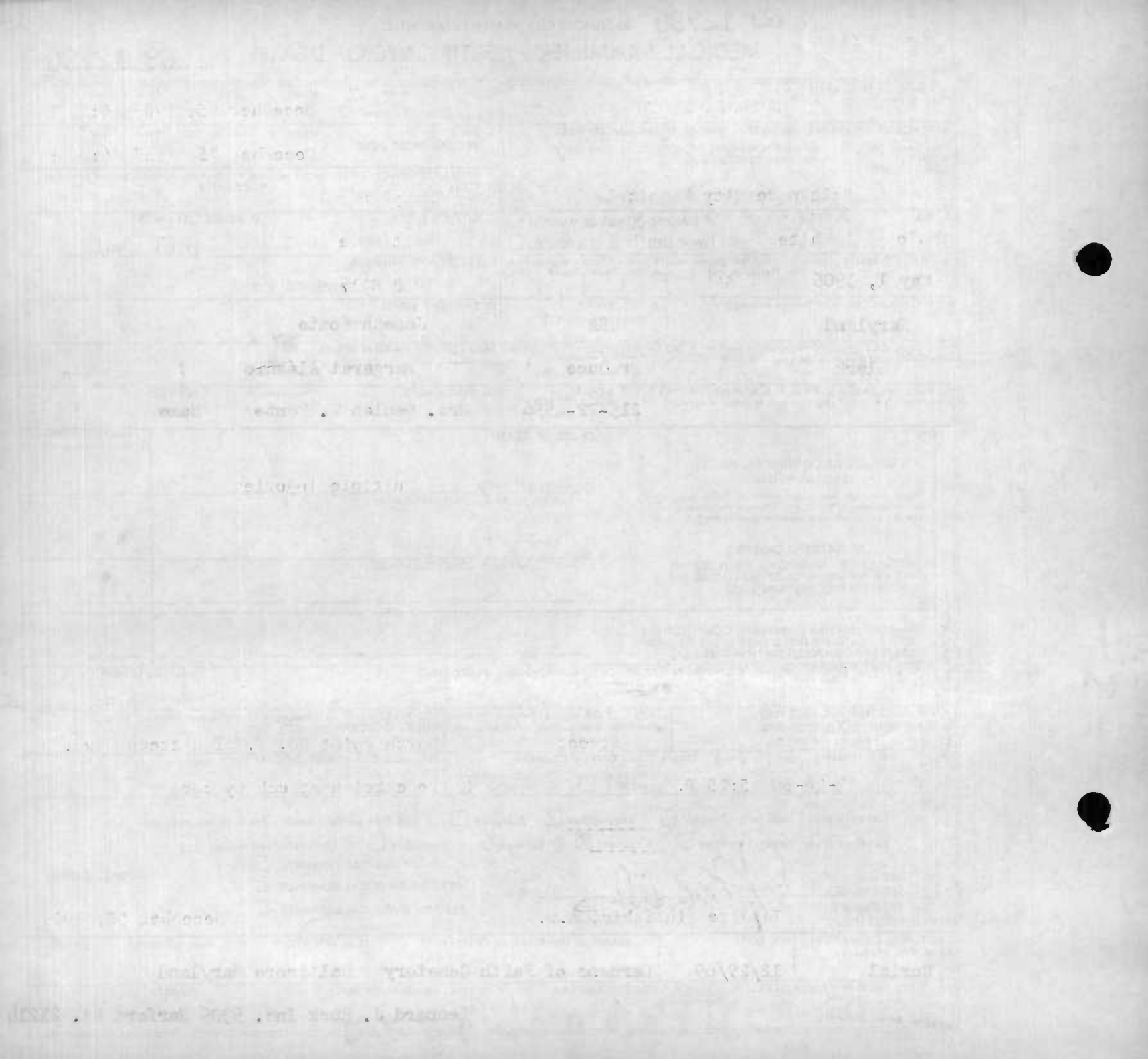
Very truly yours,  
[Illegible Signature]

Enclosed for the Bureau are two copies of a letterhead memorandum (LHM) dated 10-1-54.

The LHM is being furnished to the Bureau for its information.



BIRTH NO.		REG. NO.	
F-530		69 12790	
BALTIMORE CITY HEALTH DEPARTMENT			
MEDICAL EXAMINER'S CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print)		2. DATE OF DEATH	
CARMELLO FONTE		Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		3. DATE PRONOUNCED DEAD	
31 Baltimore City Hospital		Month Day Year	
6. SEX		7. RACE	
Male		White	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		C. CITY OR TOWN	
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Baltimore	
9. DATE OF BIRTH		D. INSIDE CITY LIMITS?	
May 1, 1905		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
10. AGE (In years lost birth day)		E. STREET AND NUMBER	
64		1918 Ellanwood Road	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF	
Maryland		USA	
13. FATHER'S NAME		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
Joseph Fonte		Clerk	
15. MOTHER'S MAIDEN NAME		16. WAS DECEASED EVER IN U.S. ARMED FORCES?	
Margaret Alascio		(Yes, no or unknown) (If yes, give war or dates of service)	
17. SOCIAL SECURITY NO.		18. INFORMANT	
215-22-4556		Mrs. Beulah V. Fonte	
19. CAUSE OF DEATH		ADDRESS	
E 814.7		Same	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)			
ANTECEDENT CAUSES		(A) IMMEDIATE CAUSE	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		Multiple injuries	
		DUE TO, OR AS A CONSEQUENCE OF:	
		(B) DUE TO, OR AS A CONSEQUENCE OF:	
		(C) DUE TO, OR AS A CONSEQUENCE OF:	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22D. TIME OF INJURY (APPROX.)	
North Point Rd. S. of Eastern Blvd.		12-24-69 5:25 P. m.	
22E. INJURY OCCURRED		22F. HOW DID INJURY OCCUR?	
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		Pedestrian struck by car	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE		CHIEF MEDICAL EXAMINER	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
Isidore Mihalakis, M.D.		ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
DATE SIGNED		December 26, 1969	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE	
Burial		12/29/69	
24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Gardens of Faith Cemetery		Baltimore Maryland	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR	
DEC 29 1969		Leonard J. Ruck Inc. 5305 Harford Rd. 21214	



1  
S-530 69 12791 BALTIMORE CITY HEALTH DEPARTMENT  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH REG. NO. 69 12791

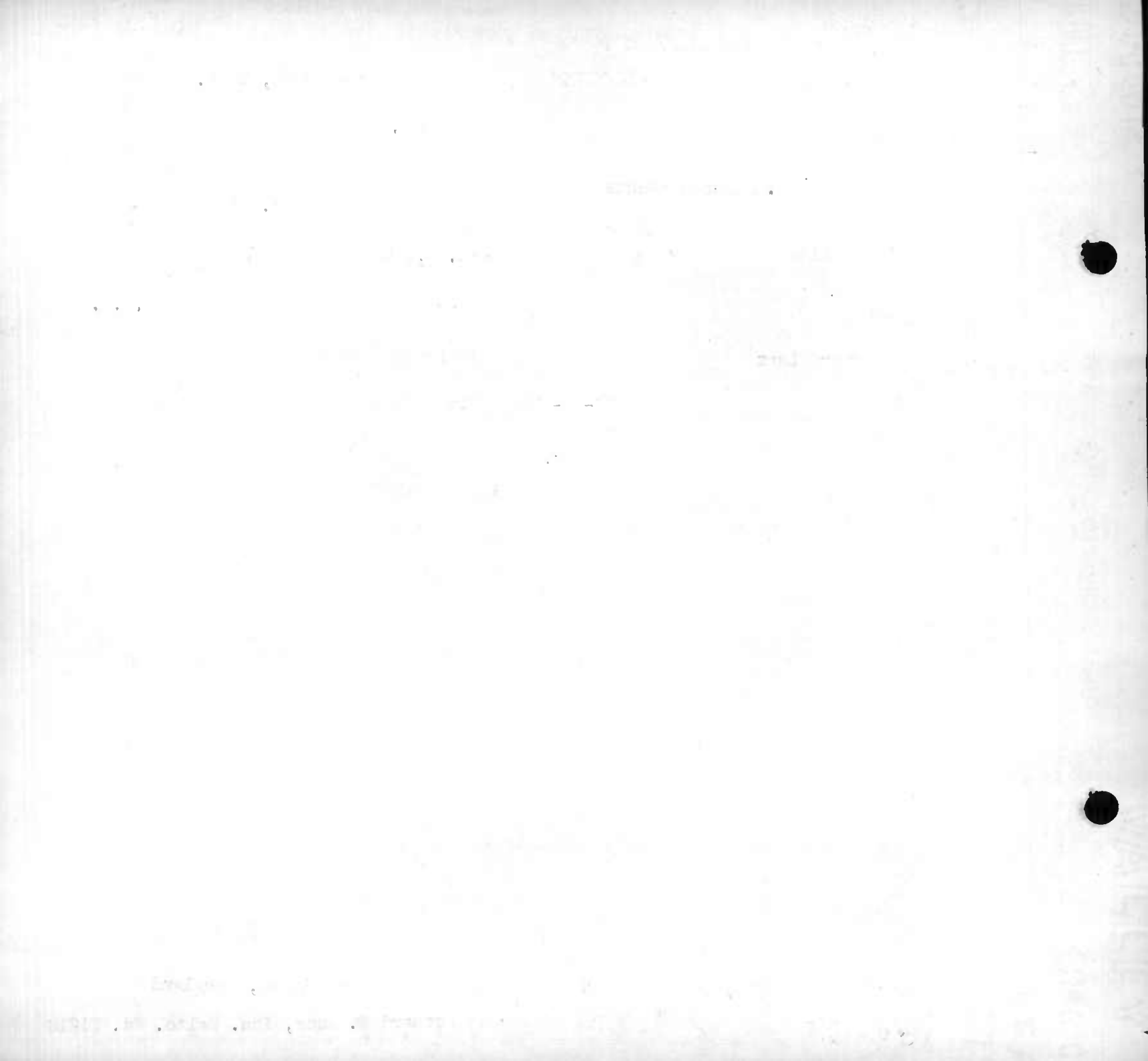
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>SUSIE SMITH</b>		2. DATE OF DEATH Known <input type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>16 S. Ann Street (DOA)</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>December 20, 1969 12:10 P.M.</b>		5. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>202</b>	
6. SEX <b>Female</b>	7. RACE <b>White</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		C. CITY OR TOWN <b>Baltimore</b>	
9. DATE OF BIRTH <b>June 20, 1905</b>		10. AGE (In years lost birthday) <b>64</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF <b>U.S.A.</b>		E. STREET AND NUMBER <b>16 S. Ann Street</b>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Factory Worker</b>		14B. KIND OF BUSINESS OR INDUSTRY		13. FATHER'S NAME <b>George Masten</b>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		17. SOCIAL SECURITY NO.		15. MOTHER'S MAIDEN NAME <b>Martha Martin</b>	
18. INFORMANT <b>Mrs Fannie Carter</b>		ADDRESS <b>16 S. Ann St Baltimore, Md.</b>			
19. <b>412.41-250.9</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>Diabetes Mellitus</b>		CAUSE OF DEATH <b>Arteriosclerotic Cardiovascular Disease</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:  (B) DUE TO, OR AS A CONSEQUENCE OF:  (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION <b>0</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) <b>no</b>	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>  ACTUAL SIGNATURE <b>Isidore Mihalakis, M.D.</b> M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) <b>Isidore Mihalakis, M.D.</b> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <b>12/21/69</b> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>					
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12/23/69</b>		24C. NAME OF CEMETERY or CREMATORY <b>Oak Wood</b>	
24D. LOCATION (City, town, or county) (State) <b>Richmond, Virginia</b>		25A. DATE REC'D BY HEALTH DEPT. <b>DEC 29 1969</b>			
25B. NAME OF REGISTRAR <b>Robert E. Taylor, M.D.</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Leonard J Ruck Inc. Baltimore, Maryland</b>			

ACADEMIC & TECHNICAL

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Z-566		69 12792		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 69 12792	
BIRTH NO.				1			
1. NAME OF DECEASED (Type or Print)				KATHERINE R ZIMMERER		2. DATE AND HOUR OF DEATH December 23, 1969. 9 <sup>00</sup> A M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY		601	
FULL NAME OF HOSPITAL OR INSTITUTION		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
00		144 S. Ellwood Avenue		E. STREET AND NUMBER 144 S. Ellwood Avenue			
5. SEX Female	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 11, 1892	9. AGE (In years last birthday) 77	If Under 1 Yr. Months: Days: Hours: Min.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Edward Lurz				14. MOTHER'S MAIDEN NAME Emma Gottbehuet			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 213-54-0058		17. INFORMANT Mrs Calvin Lockard		ADDRESS Same	
18. 412.21 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE Hyper-tensive arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF: Cardio-vascular disease (B) Chronic arthritis DUE TO, OR AS A CONSEQUENCE OF: (C) _____				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1965 + 1960 +	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED White At <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 19 65 to Dec 23 19 69, that (I) (we) last saw the deceased alive on Dec 23 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE George D. Lippy				23B. DATE SIGNED 12/23/69		23C. PHYSICIAN'S NAME (Type) George H. Lippy	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/27/69		24C. NAME OF CEMETERY or CREMATORY Parkwood		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. DEC 29 1969		25B. NAME OF REGISTRAR Robert E. Galt		25C. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md. 21211		ADDRESS	





K-514 1

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Bodily burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

69 12793

## CERTIFICATE OF DEATH

REG. NO.

69 12793

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

KIMBALL, GEORGE E.

2. DATE AND HOUR OF DEATH

DECEMBER 27 - 1969 10:25 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

2817 W. MOSHER STREET  
BALTIMORE, MARYLAND 21216

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

MARYLAND

C. CITY OR TOWN

BALTIMORE

D. INSIDE CITY LIMITS?

YES ☒NO ☐

E. STREET AND NUMBER

2817 WEST MOSHER STREET 21216

5. SEX

MALE

6. RACE

NEGRO

7. MARRIED ☒NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

8. DATE OF BIRTH

JAN-11-1910

9. AGE (in years last birthday)

59

10. Under 1 Yr.

Months

Days

If Under 24 Hrs. Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

CRANE OPERATOR

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

ANNAPOLIS, MARYLAND

12. CITIZEN OF WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

CHARLES KIMBALL

14. MOTHER'S MAIDEN NAME

MAZIE Smothers

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

213-01-1467

17. INFORMANT

Goldie O. Kimball 2817 Mosher St.

ADDRESS

18. 16211

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxiation, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE GENERALIZED CARCINOMATOSIS DUE TO, OR AS A CONSEQUENCE OF:

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C) CARCINOMA OF THE LUNG

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

No

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)

21E. INJURY OCCURRED

While At Work ☐Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) ~~(the hospital)~~ attended the deceased from OCTOBER 23 1969 to DECEMBER 13 1969 that (I) ~~(was)~~ last saw the deceased alive on DECEMBER 13 1969 and that (in my) ~~(own)~~ opinion death occurred on the date and hour and from the causes stated above. (I) ~~(did)~~ ~~(not)~~ view the body after death.

23A. SIGNATURE

Joseph Notarangelo M.D.

Attending Phys. ☒Med. Director ☐Staff Phys. ☐

23B. DATE SIGNED

DECEMBER 28, 1969

23C. PHYSICIAN'S NAME (Type)

JOSEPH NOTARANGELO M.D.

23D. ADDRESS

301 ST. PAUL PLACE BALTIMORE 21202

24A. BURIAL CREMATION, REMOVAL (Specify)

BURIAL

24B. DATE

12-31-69

24C. NAME OF CEMETERY or CREMATORY

Arbutus Memorial Park

24D. LOCATION

Arbutus, Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.

DEC 29 1969

25B. NAME OF REGISTRAR

E. J. Barber, Jr.

25C. FUNERAL DIRECTOR

Robert J. Bailey, 1348 Y. Calhoun St.





This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

# 69 12794 CERTIFICATE OF DEATH

REG. NO. 69 12794

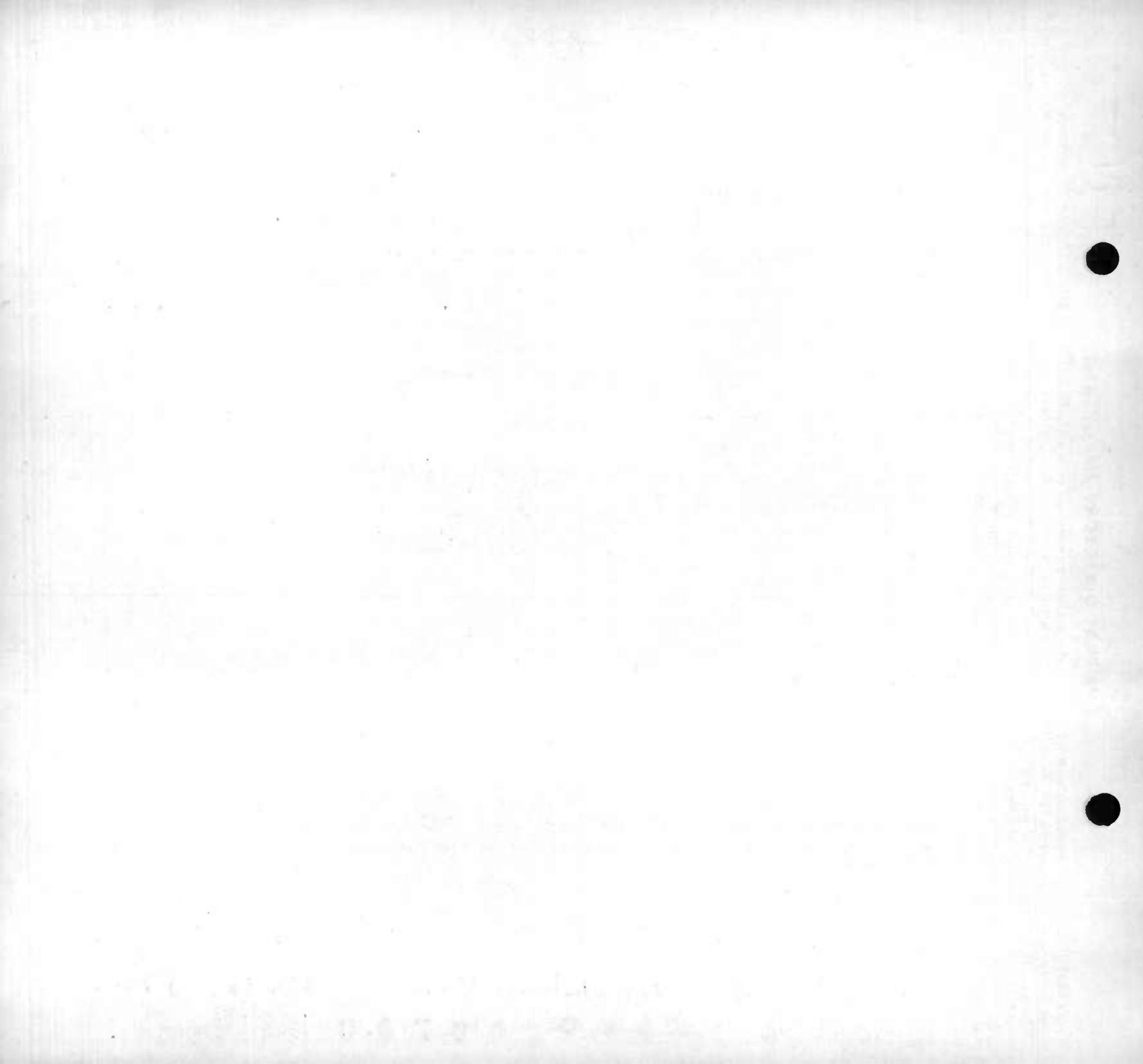
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>MARTHA MORTHAMILTON</b>		2. DATE AND HOUR OF DEATH <b>12/24/69 6:15</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>1303</b>		M.	
FULL NAME OF HOSPITAL OR INSTITUTION <b>33 THE JOHNS HOPKINS HOSPITAL</b>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <b>BALTIMORE</b>	
				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER <b>2507 WOODBROOK RD.</b>			
5. SEX <b>FEMALE</b>	6. RACE <b>NEGRO</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5-16-06</b>	9. AGE (In years last birthday) <b>63</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>md.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>WILLIAM JORDAN</b>		14. MOTHER'S MAIDEN NAME <b>SUSIE Marshall</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Isabelle Hamilton - 1544 Stricker St.</b>	
18. <b>093.91</b>		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Myocardial failure.</b>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF: <b>Arterio-sclerotic heart disease.</b>			
		(C) <b>Pneumonia.</b>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>11/30/69</b> 19 to <b>12/24/69</b> 19, that (I) (we) last saw the deceased alive on <b>12/24/69</b> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Charles S. Angell, M.D.</b>		23B. DATE SIGNED <b>12/24/69</b>			
23C. PHYSICIAN'S NAME (Type) <b>CHARLES S. ANGELL, M.D.</b>		23D. ADDRESS <b>THE JOHNS HOPKINS HOSPITAL</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12-24-69</b>		24C. NAME OF CEMETERY OR CREMATORY <b>New Cathedral Cem.</b>	
24D. LOCATION (City, town, or county) (State) <b>Balto. Md.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>DEC 29 1969</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor, M.D.</b>	
25C. FUNERAL DIRECTOR <b>Robert E. Taylor, M.D.</b>		25D. ADDRESS <b>1348 N. Calhoun St.</b>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 69 12795				BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 69 12795			
1. NAME OF DECEASED (Type or Print) <b>Lucy Smith Mack</b>				2. DATE AND HOUR OF DEATH <b>12-23-69</b>				M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)							
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>1437 Argyle Avenue</b>				A. STATE <b>Md.</b> B. COUNTY <b>1402</b>							
				C. CITY OR TOWN <b>Balto.</b>				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
				E. STREET AND NUMBER <b>1437 Argyle Ave.</b>							
5. SEX <b>Female</b>		6. RACE <b>Negroid</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>10-14-97</b>		9. AGE (In years last birthday) <b>72</b>		If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) <b>Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME							
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>				16. SOCIAL SECURITY NO.		17. INFORMANT <b>Barbara Sembly</b>				ADDRESS <b>3419 Piedmont Ave.</b>	
18. <b>410.01</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Cardiac Failure</b> (B) DUE TO, OR AS A CONSEQUENCE OF: <b>Hypertensive Cardiac Vascular Disease</b> (C) _____				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Occurring several days</b>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).											
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)							
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?							
22. I certify that (I) (this hospital) attended the deceased from <b>9-25-69</b> to <b>12-23-69</b> that (I) (we) last saw the deceased alive on <b>12-22-69</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE <b>Richard H. Hunt</b>				DEGREE <b>DEGREE</b>		23B. DATE SIGNED <b>12/27/69</b>					
23C. PHYSICIAN'S NAME (Type) <b>Richard H. Hunt</b>				DEGREE <b>DEGREE</b>		23D. ADDRESS <b>607 W. Melburn St. BALTO. MD.</b>					
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12-27-69</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Dr. Auburn Cem.</b>		24D. LOCATION (City, town, or county) (State) <b>Balto. Md.</b>					
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 29 1969</b>		25B. NAME OF REGISTRAR <b>Robert E. Bailey, MD.</b>		25C. FUNERAL DIRECTOR <b>V. Bailey</b>		ADDRESS <b>Kelson B. H. 1348 Calhoun St.</b>					



1  
B-623

BALTIMORE CITY HEALTH DEPARTMENT

69 12796

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

69 12796

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) <b>RAPHEAL BRAXTON</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year <b>December 24, 1969</b>		Hour M.
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>1105 N. Gilmore Street</b>		3. DATE PRONOUNCED DEAD Month Day Year <b>December 24, 1969</b>		Hour <b>1:20 P.</b> M.
5. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>1602</b>				
6. SEX <b>Male</b>	7. RACE <b>Negro</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Baltimore</b>
9. DATE OF BIRTH <b>3-9-19</b>		10. AGE (In years last birthday) <b>50</b>	E. STREET AND NUMBER <b>1105 N. Gilmore Street</b>	
11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>H. Braxton</b>
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY		15. MOTHER'S MAIDEN NAME <b>Lillian Christian</b>
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>yes 3/19/43 - 3/19/47</b>		17. SOCIAL SECURITY NO. <b>217079334</b>		18. INFORMANT <b>Bertha Brown</b> ADDRESS <b>1031 N. Mount St.</b>
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>57119</b> <b>Cirrhosis of liver</b>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Cirrhosis of liver</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(b) DUE TO, OR AS A CONSEQUENCE OF:		
(c)				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
20A. DATE OF OPERATION <b>2</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) <b>Yes</b>
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) (Minute) <b>m.</b>		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <b>Charles S. Springate, M.D.</b> CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) <b>Charles S. Springate, M.D.</b> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <b>December 25, 1969</b> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>				
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12-29-69</b>	24C. NAME OF CEMETERY or CREMATORY <b>Balto. Nat'l. Cem.</b>	24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 29 1969</b>		25B. NAME OF REGISTRAR <b>Robert E. Taber, M.D.</b>		25C. FUNERAL DIRECTOR <b>V. Bailey</b> ADDRESS <b>Kelson, F.H. 1348 Calhoun St.</b>

ACADEMY BOND

PAID BY DEPOSIT TO THE

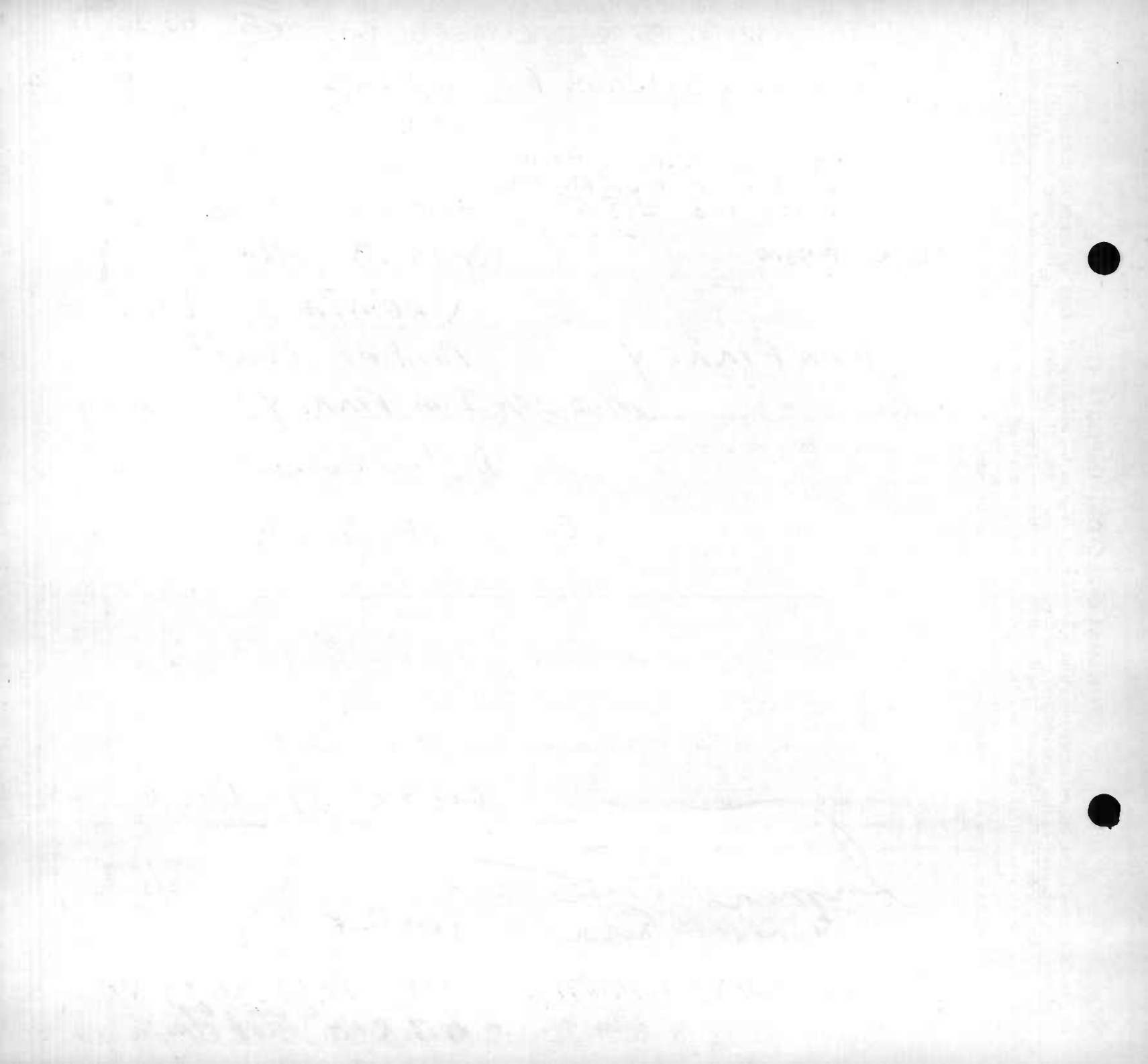
ACADEMY

# FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <b>69 12797</b>
BIRTH NO. <b>69 12797</b>		<b>CERTIFICATE OF DEATH</b>		
1. NAME OF DECEASED (Type or Print) <b>Finney, Sylvaine (Sylvanus)</b>		2. DATE AND HOUR OF DEATH <b>12/24/69 8<sup>15</sup> AM.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE <b>MD</b> B. COUNTY <b>2710</b>		
FULL NAME OF HOSPITAL OR INSTITUTION <b>90 Mt Sinai Nursing Home 4413 Park Heights Ave Balto Md 21215</b>		C. CITY OR TOWN <b>Balto</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
		E. STREET AND NUMBER <b>4800 Old York Rd</b>		
5. SEX <b>Male</b>	6. RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3-23-13</b>	9. AGE (In years lost birthday) <b>56</b> If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>		13. FATHER'S NAME <b>JOHN FINNEY</b>		
14. MOTHER'S MAIDEN NAME <b>Amber Watts</b>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		
16. SOCIAL SECURITY NO. <b>147-2-3813</b>		17. INFORMANT <b>IDA FINNEY</b> ADDRESS <b>SAME</b>		
18. <b>146.0 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Several weeks</b>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.		(A) IMMEDIATE CAUSE <b>D. House cancer metastasizing</b> DUE TO, OR AS A CONSEQUENCE OF: (B) <b>Carcinoma of Tonsils</b> DUE TO, OR AS A CONSEQUENCE OF: (C) _____		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION <b>12/23/69</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <b>Dec 23, 1969</b> to <b>Dec 24, 1969</b> , that (I) (we) last saw the deceased alive on <b>19</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <b>Seymour H. Rubin</b>		23B. DATE SIGNED <b>12/24/69</b>		23C. PHYSICIAN'S NAME (Type) <b>Seymour H. Rubin</b>
23D. ADDRESS <b>5415 Park Heights Ave Balto, Md 21215</b>		24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		
24B. DATE <b>12-28-69</b>		24C. NAME OF CEMETERY or CREMATORY <b>WHARTON CEM.</b>		24D. LOCATION (City, town, or county) (State) <b>PARKSLEY, VA.</b>
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 29 1969</b>		25B. NAME OF REGISTRAR <b>Robert F. Bailey, M.D.</b>		25C. FUNERAL DIRECTOR <b>V. BAILEY</b> ADDRESS <b>1348 CALHOUN ST.</b>







**FUNERAL DIRECTOR: IMPORTANT**

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H-4001

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="background-color: black; color: black;">[REDACTED]</span>
BIRTH NO. <span style="font-size: 1.5em;">69 12798</span>		<b>CERTIFICATE OF DEATH</b>		
1. NAME OF DECEASED (Type or Print) <span style="font-size: 1.2em;">Martha Hall</span>		2. DATE AND HOUR OF DEATH <span style="font-size: 1.2em;">Dec. 23, 1969</span> <span style="font-size: 1.2em;">7:10</span> M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <span style="font-size: 1.2em;">Park Hill Convalescent Home</span>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <span style="font-size: 1.2em;">Maryland</span> B. COUNTY <span style="font-size: 1.2em;">1302</span> C. CITY OR TOWN <span style="font-size: 1.2em;">Baltimore</span> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <span style="font-size: 1.2em;">233 Linden Ave.</span>		
5. SEX <span style="font-size: 1.2em;">Female</span>	6. RACE <span style="font-size: 1.2em;">Negro; d</span>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <span style="font-size: 1.2em;">6/9/28</span>	9. AGE (In years last birthday) <span style="font-size: 1.2em;">41</span>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">Housework</span>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <span style="font-size: 1.2em;">Baltimore, Md.</span>
12. CITIZEN OF WHAT COUNTRY? <span style="font-size: 1.2em;">U.S.A</span>		13. FATHER'S NAME <span style="font-size: 1.2em;">JOSEPH Brown</span>		
14. MOTHER'S MAIDEN NAME <span style="font-size: 1.2em;">Ellen</span>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <span style="font-size: 1.2em;">NO</span>		
16. SOCIAL SECURITY NO. <span style="font-size: 1.2em;">214-16-32548</span>		17. INFORMANT <span style="font-size: 1.2em;">Marie T. Johnson (granddaughter)</span>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <span style="font-size: 1.2em;">Bronchopneumonia</span>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <span style="font-size: 1.2em;">1 wk</span>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <span style="font-size: 1.2em;">Herd recurring hypertension approx 1 yr</span>		
(B) DUE TO, OR AS A CONSEQUENCE OF:		(C) DUE TO, OR AS A CONSEQUENCE OF:		
<b>II</b>				
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <span style="font-size: 1.2em;">No</span>
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (1) (this hospital) attended the deceased from <span style="font-size: 1.2em;">11 am</span> <span style="font-size: 1.2em;">19 69</span> to <span style="font-size: 1.2em;">23 Dec</span> <span style="font-size: 1.2em;">19 69</span> , that (1) (we) last saw the deceased alive on <span style="font-size: 1.2em;">23 Dec</span> <span style="font-size: 1.2em;">19 69</span> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.				
23A. SIGNATURE <span style="font-size: 1.2em;">J. Hull</span>		23B. DATE SIGNED <span style="font-size: 1.2em;">23 Dec 69</span>		23C. PHYSICIAN'S NAME (Type) <span style="font-size: 1.2em;">J. Hull</span>
23D. ADDRESS <span style="font-size: 1.2em;">2214 E Fayette St</span>		23E. FUNERAL DIRECTOR <span style="font-size: 1.2em;">U.R. Bailey</span>		
24A. BURIAL CREMATION, REMOVAL (Specify) <span style="font-size: 1.2em;">Burial</span>		24B. DATE <span style="font-size: 1.2em;">12-27-69</span>		24C. NAME of CEMETERY or CREMATORY <span style="font-size: 1.2em;">Mt. Auburn Cem.</span>
24D. LOCATION (City, town, or county) <span style="font-size: 1.2em;">Balto. Ord.</span>		24E. ADDRESS <span style="font-size: 1.2em;">1348 N. Calhoun St.</span>		
25A. DATE REC'D BY HEALTH DEPT. <span style="font-size: 1.2em;">DEC 29 1969</span>		25B. NAME OF REGISTRAR <span style="font-size: 1.2em;">Robert E. Taylor</span>		25C. FUNERAL DIRECTOR <span style="font-size: 1.2em;">Kelson B. H.</span>



**FUNERAL DIRECTOR: IMPORTANT**

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BALTIMORE CITY HEALTH DEPARTMENT			
69 12799		CERTIFICATE OF DEATH	
BIRTH NO.		REG. NO. 69 12799	
1. NAME OF DECEASED (Type or Print) <i>Worsham, Sherry</i>		2. DATE AND HOUR OF DEATH <i>12/21/69 10:23 P.M.</i>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION <i>Univ. of Maryland Hosp.</i>		A. STATE <i>md.</i> B. COUNTY <i>1138 N. Woodyear St. 1602</i>	
C. CITY OR TOWN <i>Baltimore</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <i>1138 Woodyear Street</i>			
5. SEX <i>M</i>	6. RACE <i>N</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>7/28/23</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		9. AGE (in years last birthday) <i>46</i>	11. BIRTHPLACE (State or foreign country) <i>Fla.</i>
10B. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>William Worsham</i>		14. MOTHER'S MAIDEN NAME <i>Ola Handerson</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>YES</i>		16. SOCIAL SECURITY NO. <i>261-16-3005</i>	
17. INFORMANT <i>Alice Worsham</i>		ADDRESS <i>As above 1138 N. Woodyear St.</i>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <i>Septicemia following Hiatus Hernia Repair</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>One week</i>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			
19A. DATE OF OPERATION <i>Nov 11, 69</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Recurrent Esophageal Hernia</i>	
20A. AUTOPSY? (Yes) <input checked="" type="checkbox"/> or No <input type="checkbox"/>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>11/5/69</i> to <i>12/21/69</i> that (I) (we) last saw the deceased alive on <i>12/21/69</i> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <i>E. Shofar MD</i>		23B. DATE SIGNED <i>12/21/69</i>	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <i>12-26-69</i>	
24C. NAME OF CEMETERY OR CREMATORY <i>Bethel Natl. Cem.</i>		24D. LOCATION (City, town, or county) (State) <i>Bethel, Md.</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>DEC 29 1969</i>		25B. NAME OF REGISTRAR <i>Robert E. Selby, Jr.</i>	
25C. FUNERAL DIRECTOR <i>W. J. Selby, Jr.</i>		ADDRESS <i>1348 Chelham St.</i>	



69 12800

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

69 12800

BIRTH NO.

## 1. NAME OF DECEASED

(Type or Print)

WILLIAM C. FENWICK

## 2. DATE OF DEATH

Known ☐ Estimated ☐

Month

Day

Year

Hour

M.

## 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

00 1732 Division Street (DOA)

## 3. DATE PRONOUNCED DEAD

Month

Day

Year

Hour

December 20, 1969

7:45 A.M.

## 5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

1402

## 6. SEX

Male

## 7. RACE

Negro

8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

## C. CITY OR TOWN

Baltimore

## D. INSIDE CITY LIMITS?

YES ☒ NO ☐

## 9. DATE OF BIRTH

11-6-24

## 10. AGE (In years last birthday)

45

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.

## E. STREET AND NUMBER

1732 Division Street

## 11. BIRTHPLACE (State or foreign country)

md.

## 12. CITIZEN OF WHAT COUNTRY?

U.S.A.

## 13. FATHER'S NAME

Wm. FENWICK

## 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

## 14B. KIND OF BUSINESS OR INDUSTRY

## 15. MOTHER'S MAIDEN NAME

MARIA WILSON

## 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

YES

## 17. SOCIAL SECURITY NO.

## 18. INFORMANT

PEARL FENWICK

## ADDRESS

SAME

19. 371.8

## CAUSE OF DEATH

## APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

## DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

Fatty Metamorphosis of the liver

## (A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

## (B)

DUE TO, OR AS A CONSEQUENCE OF:

## (C)

## II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).

MEDICAL CERTIFICATION

## 20A. DATE OF OPERATION

2

## 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

## 21. AUTOPSY? (Yes or No)

yes

22A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

## 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

## 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?

## 22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

## 22E. INJURY OCCURRED

WHILE AT WORK ☐ m.NOT WHILE AT WORK ☐

## 22F. HOW DID INJURY OCCUR?

## 23.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL SIGNATURE  
EXAMINER'S NAME (Type)

Isidore Mihalakis, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐  
ASSISTANT MEDICAL EXAMINER ☒  
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

12/20/69

## 24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

## 24B. DATE

12-24-69

## 24C. NAME OF CEMETERY or CREMATORY

Balto. Nat'l. Cem.

## 24D. LOCATION (City, town, or county)

Balto., Md.

## (State)

## 25A. DATE REC'D BY HEALTH DEPT.

DEC 29 1969

## 25B. NAME OF REGISTRAR

R. E. Taylor, M.D.

## 25C. FUNERAL DIRECTOR

V. R. Bailey

## ADDRESS

1348 Calhoun St.

AT/AD/DMY BOND

B-650

1

BALTIMORE CITY HEALTH DEPARTMENT

69 12801

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

69 12801

BIRTH NC.

1. NAME OF DECEASED (Type or Print) NATHANIEL BROWN		2. DATE OF DEATH Known <input type="checkbox"/> Estimated <input type="checkbox"/> Month 12 Day 26 Year 69 Hour 1:45 p.m.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION Provident Hospital D.O.A.		3. DATE PRONOUNCED DEAD Month December Day 26 Year 1969 Hour 1:45 p.m.	
6. SEX Male		7. RACE Negro	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Balto.	
9. DATE OF BIRTH 2-4-15		10. AGE (in years lost birthday) 54	
11. BIRTHPLACE (State or foreign country) b.c.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		14B. KIND OF BUSINESS OR INDUSTRY Longshoreman	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO. 218-09-2482	
18. INFORMANT Rosa Brown - wife		ADDRESS Same	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 4/2/41		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
22D. TIME OF INJURY (APPROX.) Month ( ) Day ( ) Year ( ) Hour ( )		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?		21. AUTOPSY? (Yes or No) No	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 12/27/69 ACTUAL SIGNATURE <i>Ronald N. Kornblum</i> M.D. EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12-30-69	
24C. NAME of CEMETERY or CREMATORY Arbutus Mem. Pk		24D. LOCATION (City, town, or county) (State) Balto., Md.	
25A. DATE REC'D BY HEALTH DEPT. DEC 29 1969		25B. NAME OF REGISTRAR R. E. Taylor, M.D.	
25C. FUNERAL DIRECTOR Kolson & Co.		ADDRESS 1348 N. Calhoun St.	



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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 69 12802	
F-200 69 12802		X	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>JEANNE Mary Sick</b>	
2. DATE AND HOUR OF DEATH <b>12/21/69 1 6:10 M.</b>		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD	
<div style="position: absolute; top: 0; left: 0; font-size: 2em; font-weight: bold; transform: rotate(-45deg);">             CERTIFICATE AMENDED           </div>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
		A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b>	
5. SEX <b>F</b> 6. RACE <b>W</b> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
8. DATE OF BIRTH <b>8 10 1929</b> 9. AGE (In years lost birthday) <b>40 years</b>		E. STREET AND NUMBER <b>12 Mc Cormic Ave.</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
10B. KIND OF BUSINESS OR INDUSTRY <b>Housewife</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>James Lester Prouty</b>		14. MOTHER'S MAIDEN NAME <b>Stella M. Wojcik</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>212 289 814</b>	
17. INFORMANT <b>F.S.H.</b>		ADDRESS	
18. <b>394 91</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>MULTIPLE PULMONARY INFARCTS + ATALECTASIS</b>	
ANTECEDENT CAUSES		(B) CHRONIC MITRAL STENOSIS DUE TO, OR AS A CONSEQUENCE OF:	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) _____	
II			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) <b>Yes</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>12/13</b> 19 <b>69</b> to <b>12/21</b> 19 <b>69</b> , that (I) <b>we</b> last saw the deceased alive on <b>12/21</b> 19 <b>69</b> and that in (my) <b>our</b> opinion death occurred on the date and hour and from the causes stated above. (I) <b>(We)</b> (did) (did not) view the body after death.			
23A. SIGNATURE <b>Louis E. Gruenewald M.D.</b>		23B. DATE SIGNED <b>12/21/69</b>	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12-24-1969</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Gardens of Faith</b>		24D. LOCATION (City, town, or county) (State) <b>Fullerton Balto. Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 29 1969</b>		25B. NAME OF REGISTRAR <b>Robert E. Jackson</b>	
25C. FUNERAL DIRECTOR <b>278 278</b>		25D. ADDRESS <b>212 26 Lassahn Funeral Home, 7401 Belair Rd.</b>	

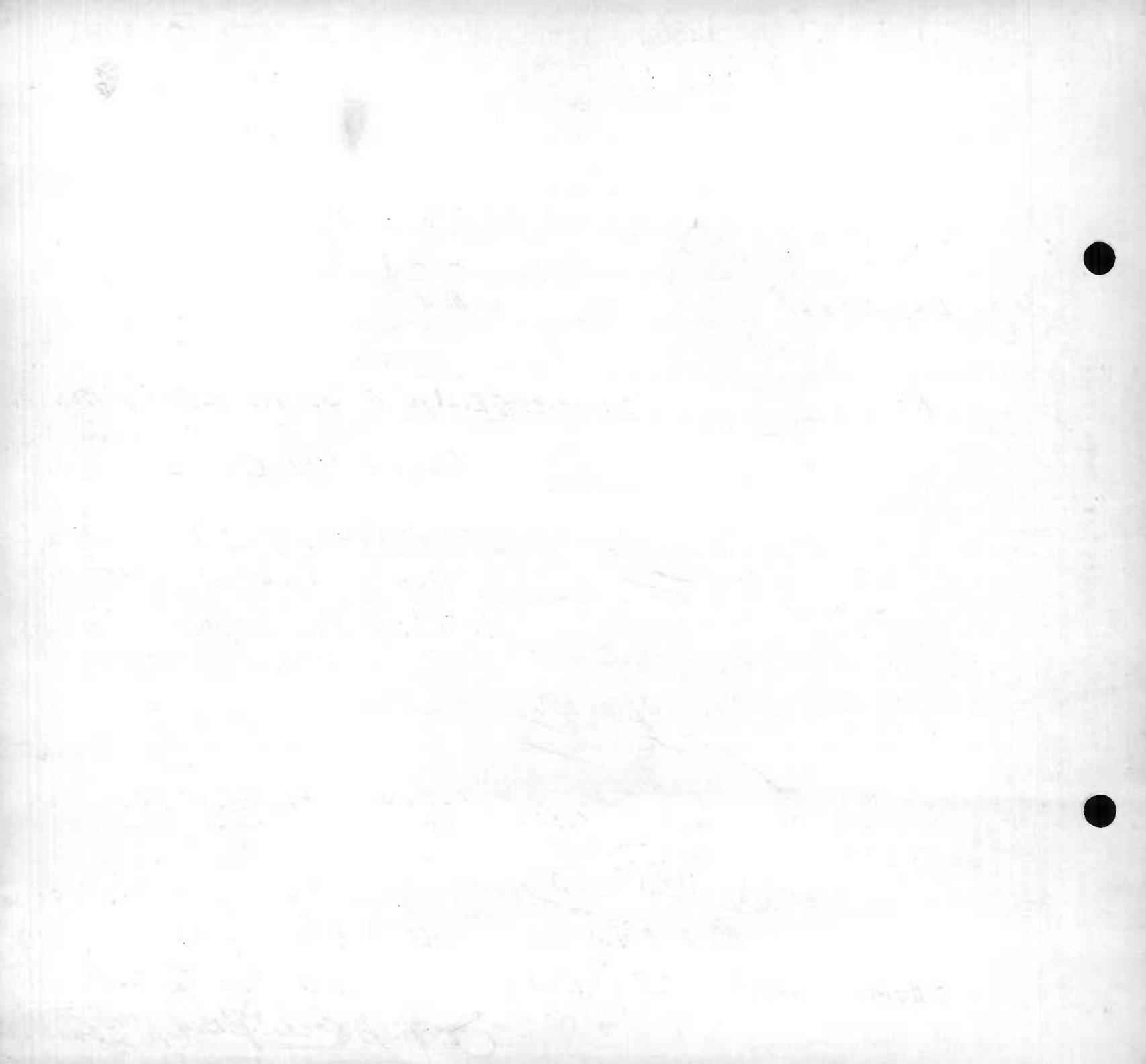
Birth Certificate D-55038 for Mary Jeanne  
Prouty born Aug. 16, 1929 in Balto. Md.  
4-8-70 M.H.

*[Faint, mostly illegible handwritten notes and signatures, possibly including names like "Mary Jeanne" and "Prouty"]*

**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

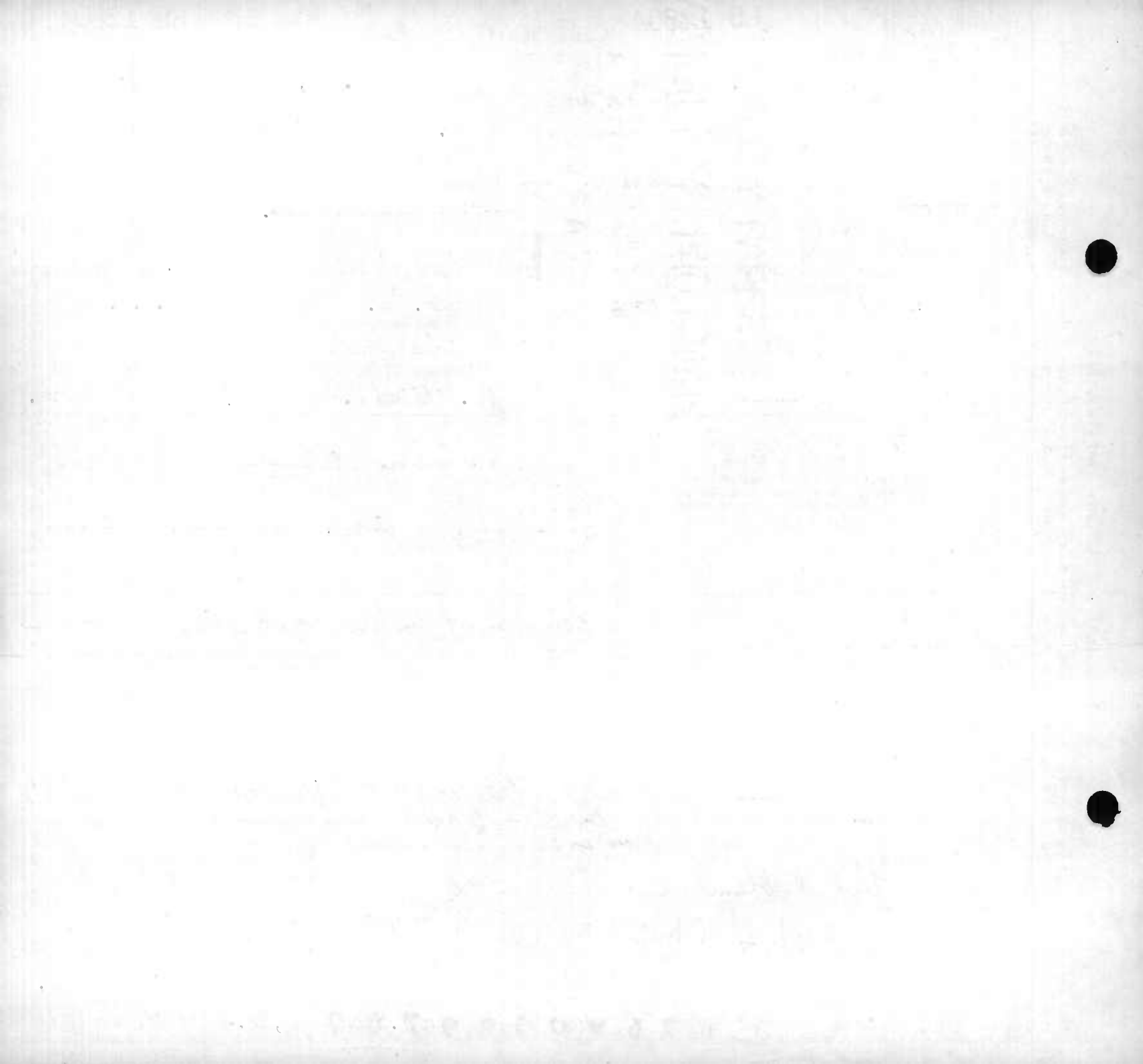
BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <b>69 12803</b>	
<b>5-162</b> <b>69 12803</b> <b>CERTIFICATE OF DEATH</b>			
1. NAME OF DECEASED (Type or Print) <b>SPRIGGS CLIFTON</b>		2. DATE AND HOUR OF DEATH <b>DEC 27 1969 4:20 A.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>33 THE JOHNS HOPKINS HOSPITAL</b>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTIMORE CITY</b> C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>1653 N. MILTON AVENUE 21213</b>	
5. SEX <b>MALE</b>	6. RACE <b>NEGRO</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3-20-17</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Longshoreman</b>		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <b>52</b>
13. FATHER'S NAME <b>ERNEST FEEBIE</b>		14. MOTHER'S MAIDEN NAME <b>LILLIAN CAMPER</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>216-07-230</b>	17. INFORMANT <b>EVERLYN C. SPRIGGS</b>
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Massive Hemorrhage</b> (B) <b>Esophageal Varices</b> DUE TO, OR AS A CONSEQUENCE OF: <b>Hepatic Cirrhosis</b> (C) <b>Metastatic Carcinoma</b>	
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>6 hrs</b>			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION <b>2</b>	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) <b>YES</b>	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>12/26 1969</b> to <b>12/27 1969</b> , that (I) (we) last saw the deceased alive on <b>12/27 1969</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.			
23A. SIGNATURE  <b>MD</b>			23B. DATE SIGNED <b>12/27/69</b>
23C. PHYSICIAN'S NAME (Type) <b>RUIZ-MORA MD</b>			23D. ADDRESS <b>601 N. Broadway Baltimore MD</b>
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>12/31/69</b>	24C. NAME OF CEMETERY or CREMATORY <b>Mt. Calvary</b>	24D. LOCATION (City, town, or county) (State) <b>Q. A. County, Md</b>
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 29 1969</b>		25B. NAME OF REGISTRAR <b>John E. [unclear]</b>	25C. FUNERAL DIRECTOR <b>John E. [unclear]</b>
ADDRESS <b>1304 N. Central Ave</b>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

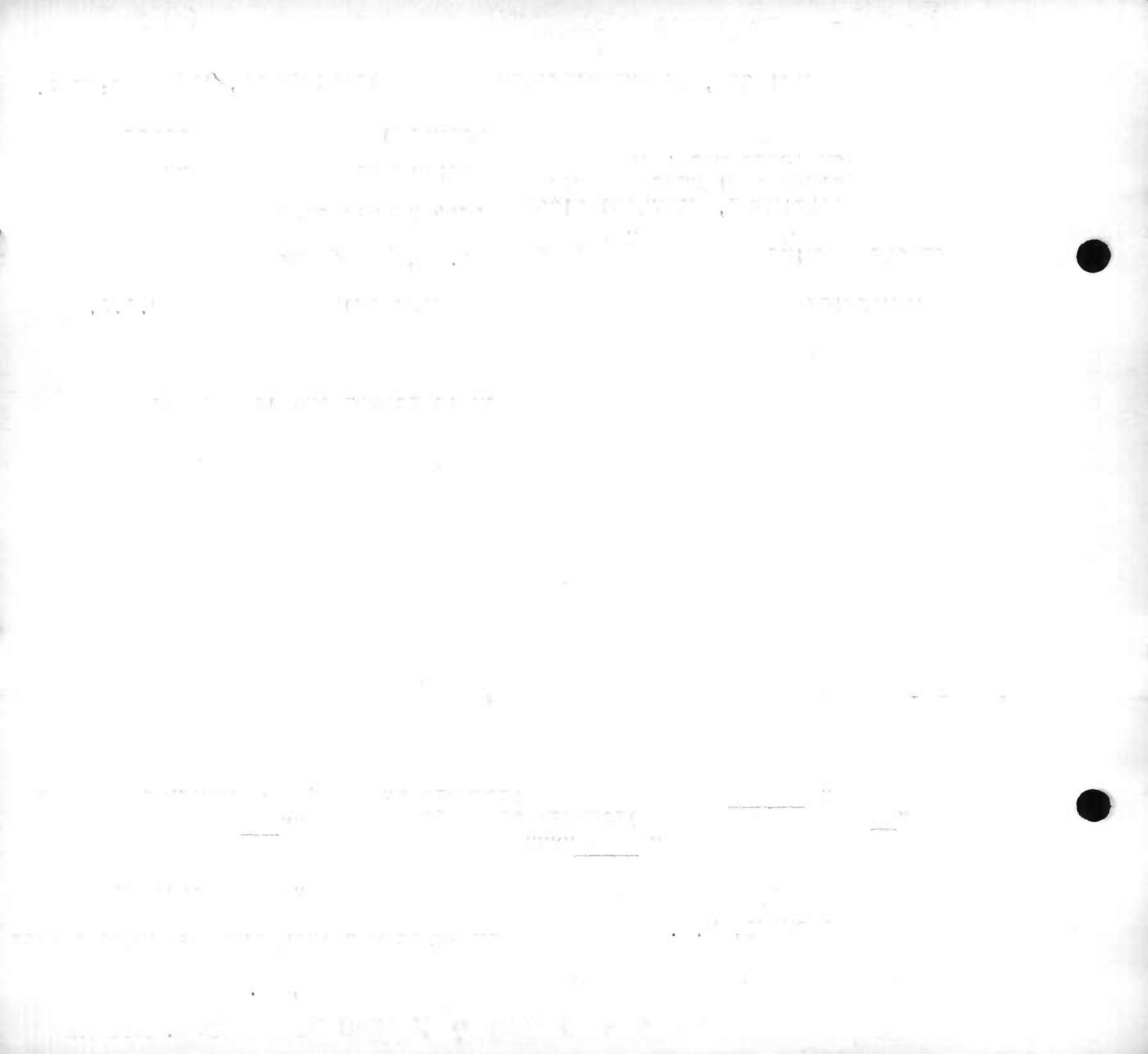
H-155		69 12804		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 69 12804	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) <i>Margaret A. Hoffman</i>			
2. DATE AND HOUR OF DEATH <i>Dec. 24, 1969</i>				3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <i>90 Anderson Nursing Home</i>			
4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <i>Md.</i> 8. COUNTY <i>Baltimore</i>				5. SEX <i>female</i> 6. RACE <i>white</i> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>90 Anderson Nursing Home</i>				9. AGE (In years last birthday) <i>88</i> 10. A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i> 10B. KIND OF BUSINESS OR INDUSTRY <i>Home</i>			
11. BIRTHPLACE (State or foreign country) <i>Balto. Md.</i>				12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			
13. FATHER'S NAME <i>Louis Reuschling</i>				14. MOTHER'S MAIDEN NAME <i>Rosa Wirth</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>no</i>				16. SOCIAL SECURITY NO. <i>-----</i>			
17. INFORMANT <i>Mr. William D. Hoffman</i>				ADDRESS <i>1931 Gwynn Oak Ave.</i>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenio, etc. It means the disease, injury or complication which caused death.) I <i>412.31</i> II <i>Generalized Arterio Sclerosis</i>				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>11 Arterio Sclerosis - Heart Disease</i> (B) <i>Chronic Brain Syndrome</i> (C) <i>2 yrs.</i>			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>- 5 yrs.</i>			
19A. DATE OF OPERATION <i>None</i> 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20A. AUTOPSY? (Yes or No) <i>No.</i> 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)			
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (the hospital) attended the deceased from <i>Oct. 7 - 1969</i> to <i>Dec. 7 - 1969</i> , that (I) last saw the deceased alive on <i>Dec. 7 - 1969</i> and that in (my) opinion death occurred on the date and hour and from the causes stated above. (I) (did not) view the body after death.							
23A. SIGNATURE <i>Earl L. Chambers</i>				23B. DATE SIGNED <i>12/26/69</i>			
23C. PHYSICIAN'S NAME (Type) <i>Earl L. Chambers</i>				23D. ADDRESS <i>100 - W. Cold Spring Lane Baltimore, Md.</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>				24B. DATE <i>12/27/69</i>			
24C. NAME OF CEMETERY or CREMATORY <i>Druid Ridge</i>				24D. LOCATION (City, town, or county) (State) <i>Pikesville Baltimore Md.</i>			
25A. DATE REC'D BY HEALTH DEPT. <i>DEC 29 1969</i>				25B. NAME OF REGISTRAR <i>John E. Jolley</i>			
25C. FUNERAL DIRECTOR <i>John T. Starbury, Sr.</i>				ADDRESS <i>6411 Windsor Mill Rd</i>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<div style="display: flex; justify-content: space-between;"> <span>K-252</span> <span>69 12805</span> <span>BALTIMORE CITY HEALTH DEPARTMENT</span> </div> <h2 style="text-align: center;">CERTIFICATE OF DEATH</h2>		REG. NO. <span style="font-size: 1.5em;">69 12805</span>	
1. NAME OF DECEASED (Type or Print) <b>REISINGER, BERTHA MARGARET</b>		2. DATE AND HOUR OF DEATH <b>DECEMBER 28, 1969 5:00 A. M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <div style="font-size: 2em; position: absolute; left: -50px; top: 50px;">40</div> <b>ST AGNES HOSPITAL CATON &amp; WILKENS AVENUES BALTIMORE E, MARYLAND 21229</b>		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>21230 25-53</b> C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>2524 TOLLEY STREET</b>	
5. SEX <b>FEMALE</b>	6. RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 14, 1888</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>	9. AGE (in years last birthday) <b>81</b>
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Joseph Jones</b>		14. MOTHER'S MAIDEN NAME <b>Isabelle Clay</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>ST AGNES HOSPITAL'S RECORDS</b>		ADDRESS	
18. <b>410.9 I</b> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (A) IMMEDIATE CAUSE <b>Acute Myocardial infarction</b> DUE TO, OR AS A CONSEQUENCE OF: <b>Arteriosclerotic Cardio-vascular disease</b> (B) <b>Heart block</b> DUE TO, OR AS A CONSEQUENCE OF: <b>A.</b> (C) <b>cardio-genic Shock.</b> II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) <b>NO</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>DECEMBER 27</b> 19 <b>69</b> to <b>DECEMBER 28</b> 19 <b>69</b> that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>DECEMBER 28</b> 19 <b>69</b> and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) <input checked="" type="checkbox"/> (not) view the body after death.			
23A. SIGNATURE <b>A. Shams, M.D.</b>		23B. DATE SIGNED <b>12/28/69</b>	
23C. PHYSICIAN'S NAME (Type) <b>A SHAMS, M.D.</b>		23D. ADDRESS <b>ST AGNES HOSPITAL CATON &amp; WILKENS AVES</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12 31 1969</b>	
24C. NAME OF CEMETERY OR CREMATORY <b>Meadowridge</b>		24D. LOCATION (City, town, or county) (State) <b>Dorsey, Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 29 1969</b>		25B. NAME OF REGISTRAR <b>Charles J. Kelly</b>	
25C. FUNERAL DIRECTOR <b>McGully</b>		ADDRESS <b>130 E. Fort Ave</b>	





69 12806				BALTIMORE CITY HEALTH DEPARTMENT				X			
MEDICAL EXAMINER'S CERTIFICATE OF DEATH								REG. NO. 69 12806			
BIRTH NO.											
1. NAME OF DECEASED (Type or Print) JULIA DISNEY						2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.					
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 38 UNIVERSITY HOSPITAL						3. DATE PRONOUNCED DEAD Month Day Year Hour December 20, 1969 11:00 A. M.					
5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY Anne Arundel						C. CITY OR TOWN Glen Burnie					
6. SEX Female		7. RACE White		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
9. DATE OF BIRTH June 5, 1926		10. AGE (in years lost birthday) 45		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		E. STREET AND NUMBER 440 Pamela Road 52-10			
13. FATHER'S NAME Marion Giles				14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Secretary				15. MOTHER'S MAIDEN NAME Matilda Melson			
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no				17. SOCIAL SECURITY NO. 215 20 1294				18. INFORMANT ADDRESS Mr. Wayne C. Turner (son) Glen Burnie, Md.			
19. E 814.1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).  Pneumonia						CAUSE OF DEATH Craniocerebral Injuries				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
						(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:					
						(B) DUE TO, OR AS A CONSEQUENCE OF:					
						(C) DUE TO, OR AS A CONSEQUENCE OF:					
20A. DATE OF OPERATION 2						20B. CONDITION FOR WHICH OPERATION WAS PERFORMED					
21. AUTOPSY? (Yes or No) yes											
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Street				22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? (Ritchie Hgwy) Md. Rte. 2 near Jones Station Rd.			
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) 12-11-69 11:50 P.				22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				22F. HOW DID INJURY OCCUR? Pedestrian stuck by car			
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>  ACTUAL SIGNATURE: <i>Isidore Mihalakis</i> M.D. DATE SIGNED: 12/21/69 EXAMINER'S NAME (Type): Isidore Mihalakis, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>											
24A. BURIAL CREMATION, REMOVAL (Specify) Burial				24B. DATE Dec. 23, 1969		24C. NAME OF CEMETERY or CREMATORY Parkwood Cemetery				24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. DEC 29 1969				25B. NAME OF REGISTRAR Valerie E. Taylor				25C. FUNERAL DIRECTOR ADDRESS Singleton Funeral Home Glen Burnie, Maryland			

1950

EXAMINER'S CERTIFICATE

Page 1 of 1

X

2

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ACADEMY FUND

*[Handwritten signature]*

1950

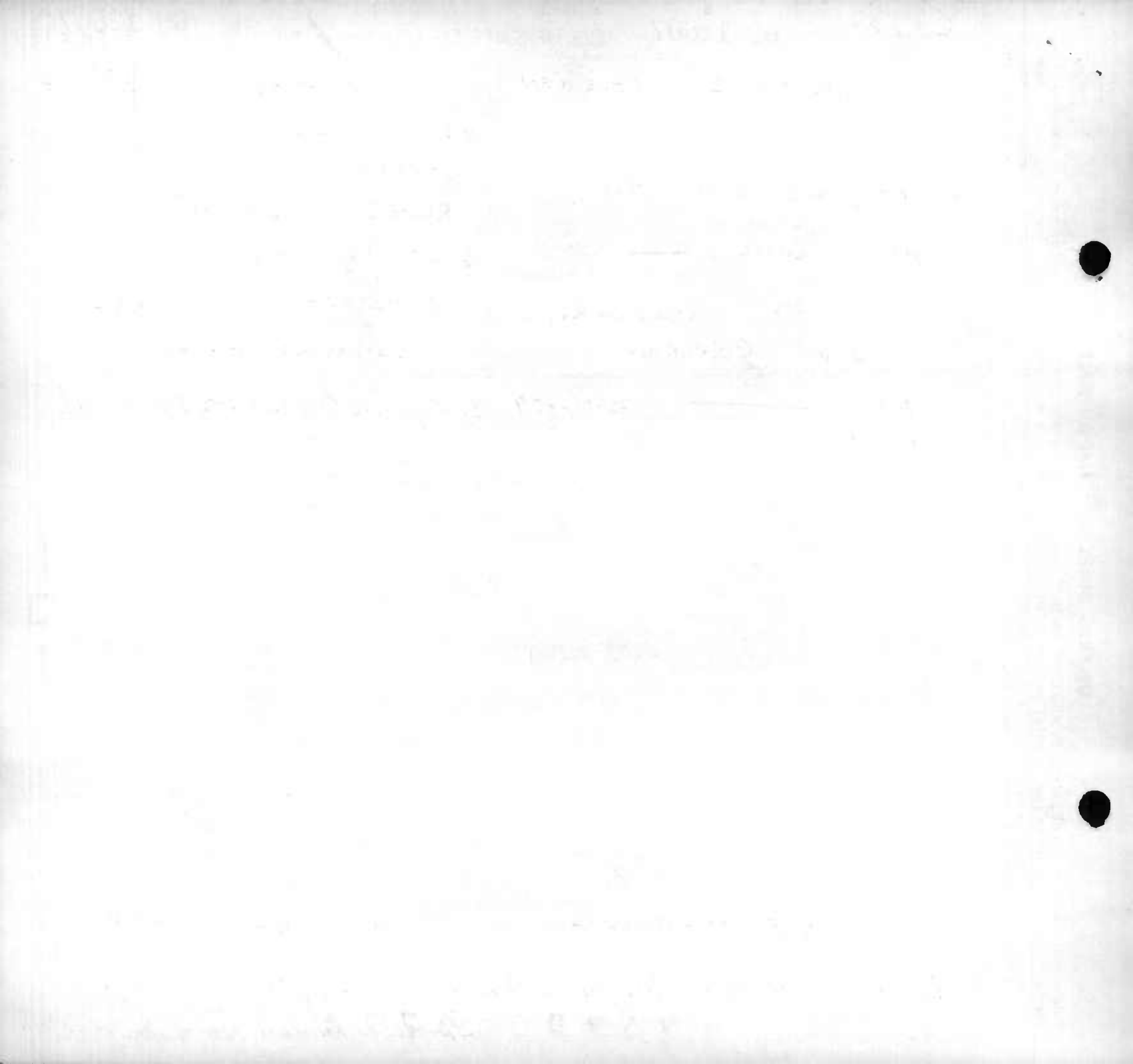
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**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

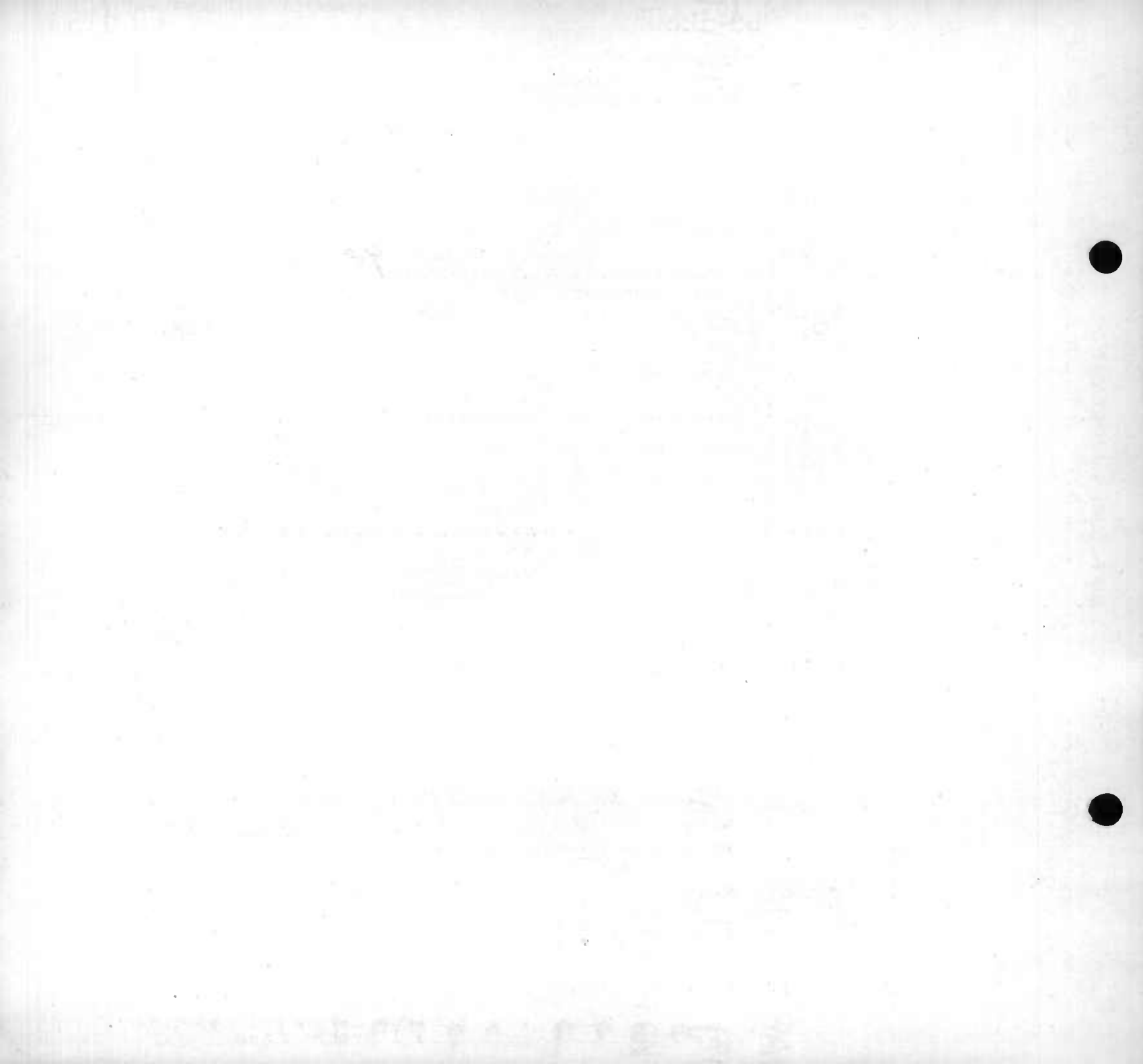
C-455		69 12807		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 69 12807					
BIRTH NO.		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>ROSCOE C. COLEMAN</b>		2. DATE AND HOUR OF DEATH <b>12/20/69 3:00 A.M.</b>					
1. NAME OF DECEASED (Type or Print)											
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MD.</b> B. COUNTY <b>A.P.C.</b>							
FULL NAME OF HOSPITAL OR INSTITUTION <b>MARYLAND GEN HOSP.</b>				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>SEVERN</b>							
(If not in hospital or institution, give street address or location)				D. STREET ADDRESS (If rural, give location) <b>Route 3 Box 125</b>							
5. SEX <b>M</b>	6. RACE <b>Cauc</b>	7. MARRIED, NEVER MARRIED <b>WIDOWED, DIVORCED (specify)</b>		8. DATE OF BIRTH <b>6-28-92</b>	9. AGE (In years last birthday) <b>77</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.					
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Coleman Des.</b>		11. BIRTHPLACE (State or foreign county) <b>MINNESOTA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>					
13. FATHER'S NAME <b>Wm Coleman</b>				14. MOTHER'S MAIDEN NAME <b>CATHARINE BAKER</b>							
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>324012659</b>		17. INFORMANT ADDRESS <b>B. EYENBROCK - Att. Odenton, Md.</b>							
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>CA - colon - metastatic</b> <b>CONGESTIVE HEART FAILURE</b> <b>(congested) 20 to ASCUT + H OVID</b>				CAUSE OF DEATH <b>CA - colon - metastatic</b> <b>CONGESTIVE HEART FAILURE</b> <b>(congested) 20 to ASCUT + H OVID</b>							
								INTERVAL BETWEEN ONSET AND DEATH			
								OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)							
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?							
22. I certify that (I) (this hospital) attended the deceased from <b>12-3 1969</b> to <b>12-20 1969</b> , that (I) (we) last saw the deceased alive on <b>12/20/69</b> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE <b>M. F. Whitworth</b>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>12-20-69</b>					
23C. PHYSICIAN'S NAME (Type) <b>M. F. WHITWORTH</b>				23D. ADDRESS <b>MD. GEN HOSP</b>							
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12/24/69</b>		24C. NAME of CEMETERY or CREMATORY <b>Sleepy Hollow Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Tarrytown New York</b>					
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 29 1969</b>		25B. NAME OF REGISTRAR <b>Robert E. ...</b>		25C. FUNERAL DIRECTOR <b>Robert E. ...</b>		ADDRESS <b>Springfield Funeral Home / Glen Burnie, Md.</b>					



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

L-630		69 12808		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 69 12808	
<div style="display: flex; justify-content: space-between;"> <div> <b>BIRTH NO.</b>                  1. NAME OF DECEASED                  (Type or Print) <b>EMMA C. LORD</b> </div> <div> <b>2. DATE AND HOUR OF DEATH</b>  <b>12-23-69 6:30 P.M.</b> </div> </div>							
<b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b>  FULL NAME OF HOSPITAL OR INSTITUTION <b>44 NORTH CHARLES BEN. HSP.</b>				<b>4. USUAL RESIDENCE</b> (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>9-03</b> C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>3313 WESTERWALD RD.</b>			
<b>5. SEX</b> <b>F</b>	<b>6. RACE</b> <b>W</b>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>9-20-90</b>	<b>9. AGE</b> (In years last birthday) <b>79</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	<b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>RETIRED</b>	
<b>10B. KIND OF BUSINESS OR INDUSTRY</b> <b>housekeeper at home</b>			<b>11. BIRTHPLACE</b> (State or foreign country) <b>Maryland</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>		
<b>13. FATHER'S NAME</b> <b>Alphonso ANPHSO LORD</b>			<b>14. MOTHER'S MAIDEN NAME</b> <b>Sophia KUHLMANN</b>				
<b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service)			<b>16. SOCIAL SECURITY NO.</b> <b>213-14-9095</b>		<b>17. INFORMANT</b> <b>PT.'S HOSPITAL CHART</b> ADDRESS		
<b>18. CAUSE OF DEATH</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
<b>19A. DATE OF OPERATION</b> <b>0</b>		<b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b>		<b>20A. AUTOPSY?</b> (Yes or No)		<b>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</b>	
<b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner) <input type="checkbox"/>		<b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		<b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)			
<b>21D. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (APPROX.)		<b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		<b>21F. HOW DID INJURY OCCUR?</b>			
<b>22. I certify that (I) (this hospital) attended the deceased from 12-21-1969 to 12-23-1969, that (I) (we) lost saw the deceased alive on 12-23-1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</b>							
<b>23A. SIGNATURE</b> <b>Macabring MB</b>				<b>23B. DATE SIGNED</b> <b>12/23/69</b>		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>	
<b>23C. PHYSICIAN'S NAME</b> (Type)				<b>23D. ADDRESS</b> <b>NORTH CHARLES BEN. HOSPITAL</b>			
<b>24A. BURIAL CREMATION, REMOVAL</b> (Specify) <b>Burial</b>		<b>24B. DATE</b> <b>12/26/69</b>		<b>24C. NAME of CEMETERY or CREMATORY</b> <b>Baltimore Cemetery</b>		<b>24D. LOCATION</b> (City, town, or county) (State) <b>Baltimore, Md.</b>	
<b>25A. DATE REC'D BY HEALTH DEPT.</b>		<b>25B. NAME OF REGISTRAR</b> <b>1969000</b>		<b>25C. FUNERAL DIRECTOR</b> <b>Schuneker Funeral Home, Inc.</b> ADDRESS <b>9331 Brehms Lane</b>			



1  
U-365 69 12809 BALTIMORE CITY HEALTH DEPARTMENT  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH REG. NO. 69 12809

BIRTH NO.		1. NAME OF DECEASED (Type or Print) Joseph William Uttermohlen		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/>		Month Day Year Hour	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		3. DATE PRONOUNCED DEAD Month Day Year Hour		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		M.	
00 3534 Belair Rd.		12 23 69 6:35 a.m.		A. STATE Maryland B. COUNTY 8-31			
6. SEX male	7. RACE white	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN 3534 Belair Rd.		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
9. DATE OF BIRTH 4/24/1910		10. AGE (in years fast birthday) 59		E. STREET AND NUMBER Baltimore			
11. BIRTHPLACE (State or foreign country) Wheeling, W.Va.		12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME Edward V. Uttermohlen			
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tavern		14B. KIND OF BUSINESS OR INDUSTRY own business		15. MOTHER'S MAIDEN NAME Clara DeTemple			
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no		17. SOCIAL SECURITY NO.		18. INFORMANT 53 Bezold Ave. W. Minster, Md. Martha Rupert Uttermohlen, wife, 85888			
19. E 965 X		CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE Gunshot wound of head DUE TO, OR AS A CONSEQUENCE OF:					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) DUE TO, OR AS A CONSEQUENCE OF:					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		(C)					
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED				21. AUTOPSY? (Yes or No) yes	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) home		22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 3534 Belair Rd.		08-31	
22D. TIME OF INJURY (APPROX.) 12 23 69 ? a.m.		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? shot at home			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Werner U. Spitz, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 12/23/69	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/27/69		24C. NAME OF CEMETERY or CREMATORY Parkwood Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. DEC 29 1969		25B. NAME OF REGISTRAR Robert E. Miller, R.H.		25C. FUNERAL DIRECTOR Schimunek Funeral Home, Inc. 3331 Brehms Lane			







# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-400				69 12810		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 69 12810	
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH					
- Anna M. Bell				12/24/69		9 A. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE		B. COUNTY			
00				Md.		21-02			
1174 Nanticoke St.				C. CITY OR TOWN		D. INSIDE CITY LIMITS?			
				Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
E. STREET AND NUMBER				1174 Nanticoke St.					
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
Female	White	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	4/14/1891	78					
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		
Housewife			at home		St. Marys Co. Md.		U. S. A.		
13. FATHER'S NAME				14. MOTHER'S MARRIED NAME					
Benjamin Brewer				Unknown					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
no						Mrs Ella Shilow		above	
18. 285.9 I				CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				(A) IMMEDIATE CAUSE				1 day.	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				Cerebral Insufficiency					
ANTECEDENT CAUSES				(B) Anemia, severe cause				1 year	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last,				DUE TO, OR AS A CONSEQUENCE OF:					
				undetermined					
II									
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).									
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
0				no					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?					
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>							
22. I certify that (I) (this hospital) attended the deceased from 12/24 19 64 to 12/24 19 64, that (I) <del>was</del> lost saw the deceased alive on 12/24 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) <del>was</del> (did) (did not) view the body after death.									
23A. SIGNATURE				23B. DATE SIGNED					
John P. Urlock Jr. MD				12/24/69					
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS					
JOHN P. URLOCK JR MD				1227 Washington Blvd					
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county)		(State)	
Burial		12/27/69		London Park Cem.		Baltimore, Md.			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS			
DEC 29 1969		Robert E. Taylor		John J. Brown		23 Mt. St.			



55-92-43 csk

M-324

69 12811

BALTIMORE CITY HEALTH DEPARTMENT

## CERTIFICATE OF DEATH

REG. NO.

69 12811

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

Lena Mitchell

2. DATE AND HOUR OF DEATH

2:45 PM

12/23/69 M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)Baltimore City Hospitals  
4940 Eastern Ave.  
Baltimore, Md. 21224

31

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒NO ☐

E. STREET AND NUMBER

1001 Dundalk Ave. Baltimore, Md. 21224 007

5. SEX

Female

6. RACE

White

7. MARRIED ☒NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

8. DATE OF BIRTH

10-26-98

9. AGE (in years  
last birthday)

71

11. Under 1 Yr.

Months: Oys:

12. Under 24 Hrs.

Hours: Min.

10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

HOUSEWIFE

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Italy

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Bernard Camatet

14. MOTHER'S MAIDEN NAME

Pauline

15. Was Deceased Ever in U. S. Armed Forces?  
(Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL  
SECURITY NO.

217-40-8400

17. INFORMANT

4940 Eastern Ave.

ADDRESS

BCH Records: Baltimore, Md. 21224

18.

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving  
rise to the above cause (A) stating the  
UNDERLYING CONDITION last.(A) IMMEDIATE CAUSE  
DUE TO, OR AS A CONSEQUENCE OF:

cardiac arrest

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

1/2 - 1 hour

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C) DUE TO, OR AS A CONSEQUENCE OF:

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART 1 (A).

congestive heart failure 3 wks

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

NO

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING  
OR CONTRIBUTING CAUSE OF  
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At ☐ Not While  
Work At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (1) (this hospital) attended the deceased from 12/16 19 69 to 12/23 19 69  
that (1) (we) last saw the deceased alive on 12/23 19 69 and that in (my) (our) opinion death occurred on the date  
and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Dale P. Henken M.D.

DEGREE

Attending  
Phys.Med.  
DirectorStaff  
Phys. ☒

23B. DATE SIGNED

12/23/69

23C. PHYSICIAN'S  
NAME (Type)

Dale P. Henken M.D.

DEGREE

23D. ADDRESS

Baltimore City Hospitals

4940 Eastern Ave. Baltimore, Md. 21224

24A. BURIAL, CREMATION,  
REMOVAL (Specify)

BURIAL

24B. DATE

12-26-69

24C. NAME OF CEMETERY OR CREMATORY

OAK LAWN

24D. LOCATION

(City, town, or county)

BALTO. CO., MD

(State)

25A. DATE REC'D BY HEALTH DEPT.

DEC 29 1969

25B. NAME OF REGISTRAR

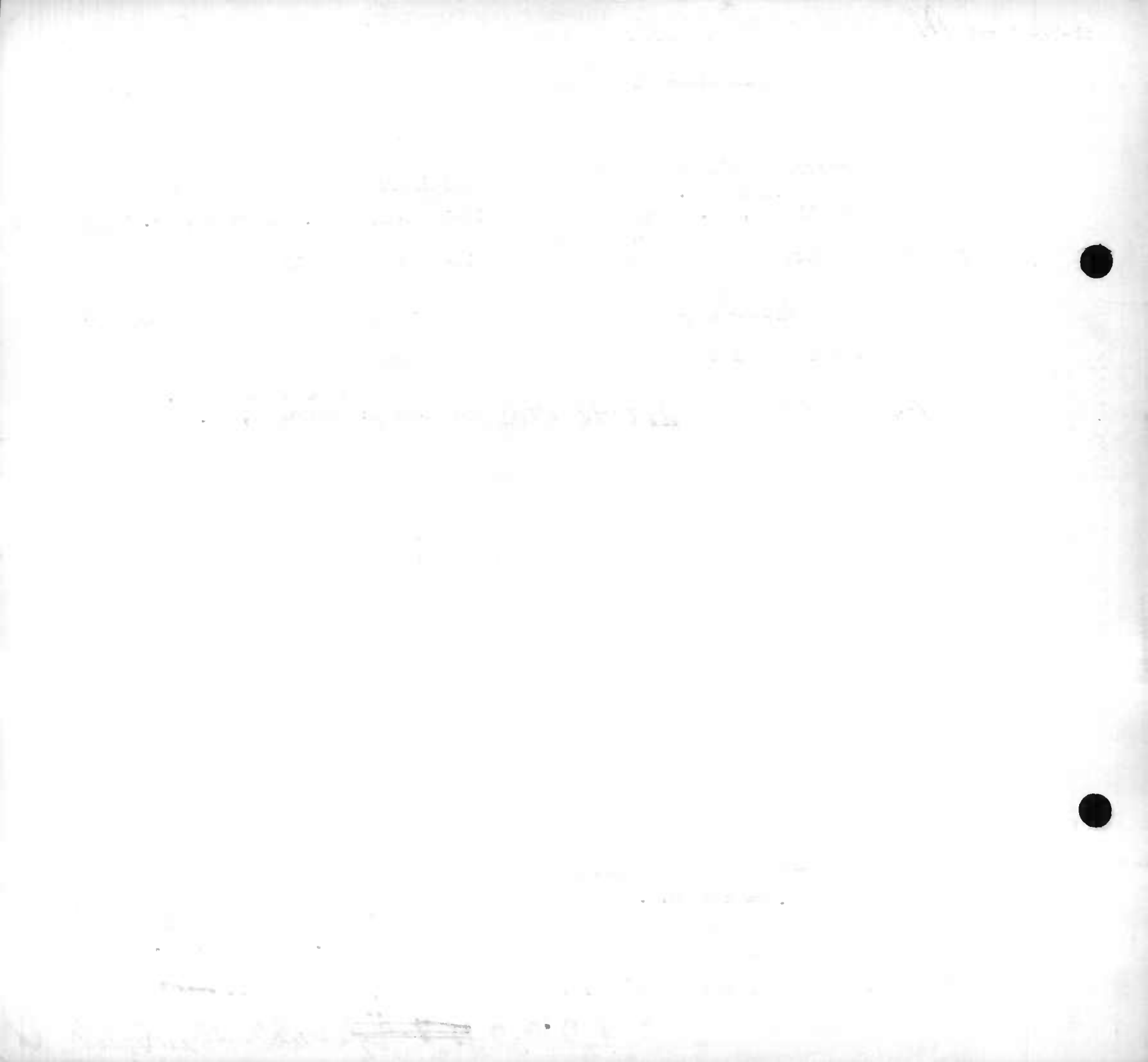
E. J. B. 000

25C. FUNERAL DIRECTOR

ADDRESS

J. J. B. 1111 Dundalk, Md.

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <span style="background-color: black; color: black;">[REDACTED]</span>
BIRTH NO. <span style="font-size: 2em;">69 12812</span>		69 12812		
1. NAME OF DECEASED (Type or Print) <b>LENTZ, STUART James</b>		2. DATE AND HOUR OF DEATH <b>12-23-69 6:40 A.M.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <b>SINAI HOSPITAL OF BALTIMORE</b>		A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTIMORE</b>		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <b>BALTIMORE</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
		E. STREET AND NUMBER <b>3029 Oakley Avenue.</b>		
5. SEX <b>MALE</b>	6. RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5/29/1884</b>	9. AGE (In years last birthday) <b>85</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Poultry Stall</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Food</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Charles Henry Lentz</b>		
14. MOTHER'S MAIDEN NAME <b>Katherine (Kate) Kreiner</b>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		
16. SOCIAL SECURITY NO. <b>215 05 2959</b>		17. INFORMANT <b>D.R. IKIRIKO</b> ADDRESS <b>SINAI HOSPITAL</b>		
18. <b>562.1 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>UREMIA</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>CONGESTIVE CARDIAC FAILURE</b> <b>Generalised Peritonitis</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>Ruptured sigmoid diverticulitis</b>				
19A. DATE OF OPERATION <b>12-14-69</b>	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Ruptured Sigmoid Diverticulitis</b>	20A. AUTOPSY? (Yes or No) <b>No</b>	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from <b>12-14-1969</b> to <b>12-23-1969</b> that (I) (we) last saw the deceased alive on <b>12-23-1969</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <i>[Signature]</i> <b>9060</b>		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>12-23-69</b>
23C. PHYSICIAN'S NAME (Type) <b>DR. SAGBE K. IKIRIKO M.D.</b>		23D. ADDRESS <b>SINAI HOSPITAL OF BALTIMORE</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>26 Dec. 69</b>	24C. NAME OF CEMETERY OR CREMATORY <b>New Cathedral Cemetery</b>	24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 29 1969</b>		25B. NAME OF REGISTRAR <i>[Signature]</i>		25C. FUNERAL DIRECTOR <i>[Signature]</i> <b>4611 Park Heights Avenue</b>



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				REG. NO. 69 12813	
F-425 69 12813		<b>CERTIFICATE OF DEATH</b>			
1. NAME OF DECEASED (Type or Print) <b>MAX FLEISCHMAN</b>		2. DATE AND HOUR OF DEATH <b>12-23-69 1 2:00 P.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>Sinai Hosp</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>5300</b>			
		C. CITY OR TOWN <b>Balto</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER <b>6954 Melbrook Park Drive</b>			
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>12/25/1898</b>	9. AGE (In years last birthday) <b>70</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Ret</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Germany</b>	
13. FATHER'S NAME <b>Karl</b>		14. MOTHER'S MAIDEN NAME <b>Bertha</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>218-128466</b>		17. INFORMANT <b>Mrs Lucy Fleischmann Samel</b>	
18. <b>410.9 + 250.9</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Myocardial Infarction</b> (B) <b>Atherosclerosis</b> (C) <b>Diabetes Mellitus</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Minutes</b> <b>years</b> <b>years</b>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A) <b>II</b>					
19A. DATE OF OPERATION <b>D</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>Dec 28</b> 19 <b>65</b> to <b>Dec 23</b> 19 <b>69</b> , that (I) (we) last saw the deceased alive on <b>Dec 28</b> 19 <b>69</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>David I. Miller</b>		DEGREE <b>Attending Phys.</b>		23B. DATE SIGNED <b>12-23-69</b>	
23C. PHYSICIAN'S NAME (Type) <b>David I. Miller, M.D.</b>		23D. ADDRESS <b>9115 Reisterstown Rd. Owings Mills, Md.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12/24/69</b>		24C. NAME OF CEMETERY or CREMATORY <b>Chase-Chase-Closed</b>	
24D. LOCATION (City, town, or county) <b>Randallstown</b>		24E. STATE <b>Md</b>		24F. COUNTY	
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 28 1969</b>		25B. NAME OF REGISTRAR <b>Robert E. Fisher</b>		25C. FUNERAL DIRECTOR <b>Sylvan Lewis &amp; Son Inc</b>	
25D. ADDRESS <b>9610 Reisterstown</b>					

Wrote the first part of the letter

March

at 11

at 11:00 AM - 11:30 AM

11:00 AM

11:30 AM

11:30 AM

11:30 AM

11:30 AM

11:30 AM

11:30 AM - 11:45 AM

11:45 AM

11:45 AM

11:45 AM

11:45 AM

11:45 AM - 12:00 PM

12:00 PM

12:00 PM

12:00 PM

12:00 PM

12:00 PM

12:00 PM

12:00 PM - 12:15 PM



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

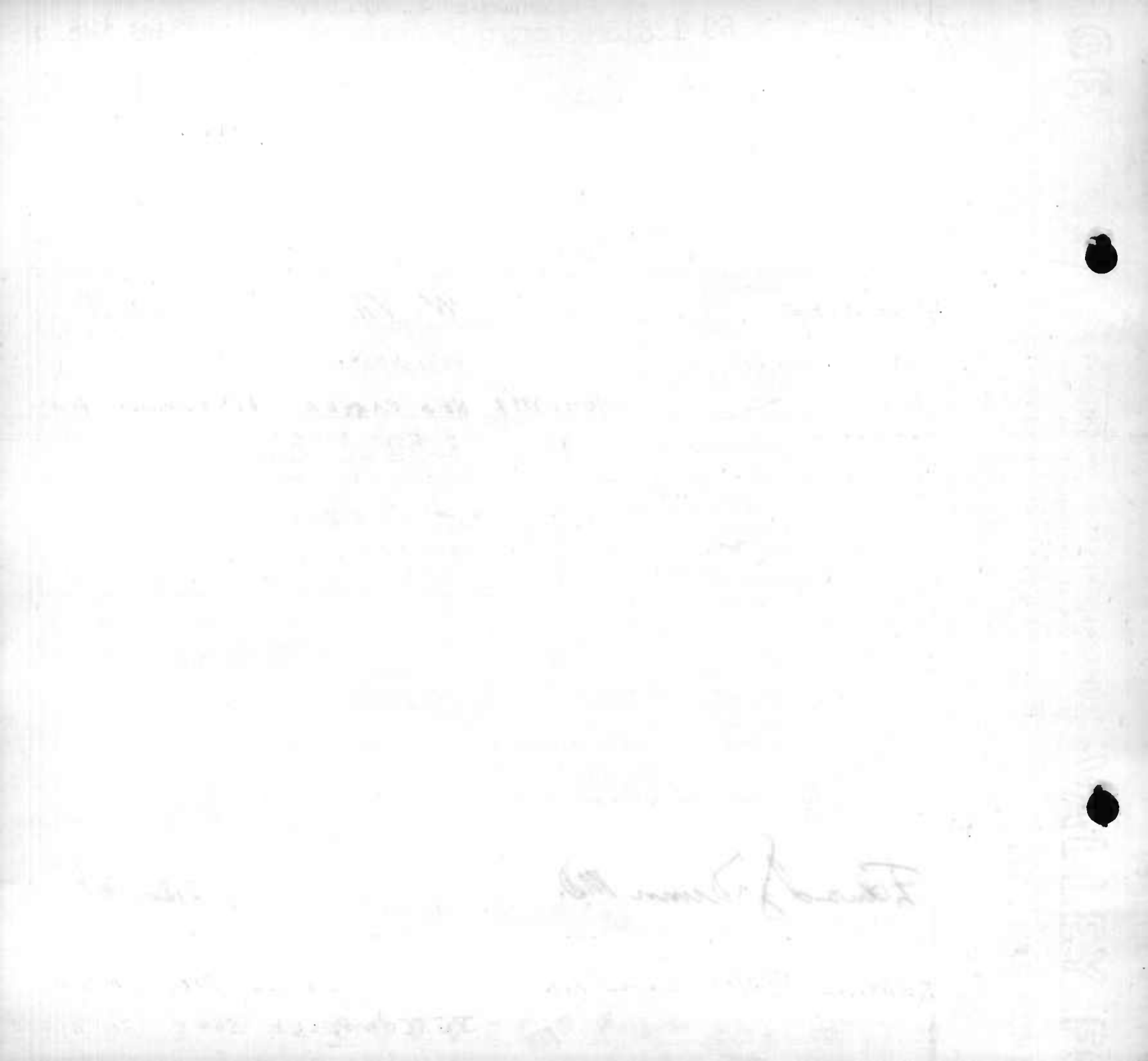
BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <span style="float: right;">69 12814</span>	
M-650 69 12814		CERTIFICATE OF DEATH	
BIRTH NO.		2. DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print) <b>Dominic James Moran</b>		<b>Dec. 26, 1969</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION <b>Jenkins Memorial</b> <b>1000 Caton Avenue</b> <b>Baltimore, Md. 21229</b>		A. STATE <b>Md.</b> B. COUNTY <b>(City Ellicott) Howard</b>	
C. CITY OR TOWN <b>Ellicott</b>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
E. STREET AND NUMBER <b>9878 Old Annapolis Road</b>			
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2-20-1899</b>
		9. AGE (In years last birthday) <b>70</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Mechanic</b>		10B. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Scranton, Pa.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Patrick J. Moran</b>		14. MOTHER'S MAIDEN NAME <b>Laura McDonough</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Unknown</b>		16. SOCIAL SECURITY NO. <b>212-14-3298</b>	
17. INFORMANT <b>Lillian M. Moran-Stella Maris Hospice</b> <b>Jenkins Memorial 1000 Caton Ave., Balto. Md.</b>		ADDRESS	
18. <b>185 X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Pneumonitis</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Cochexia</b> (B) DUE TO, OR AS A CONSEQUENCE OF: <b>Cancer prostate &amp; metastases</b> (C) <b>XSCVD</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>24 hrs</b> <b>6 months</b> <b>3 yrs</b> <b>years</b>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			
19A. DATE OF OPERATION <b>0</b>	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>10/12/1968</b> to <b>12/26/1969</b> , that (I) (we) last saw the deceased alive on <b>12/26/1969</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <b>J. Raymond Gladue</b>		23B. DATE SIGNED <b>12/27/69</b>	
23C. PHYSICIAN'S NAME (Type) <b>J. Raymond Gladue</b>		23D. ADDRESS <b>Jenkins Memorial Hospital</b>	
24A. BURIAL CREMATION REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>12-30-69</b>	24C. NAME OF CEMETERY or CREMATORY <b>Druid Ridge Cemetery</b>	24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 29 1969</b>	25B. NAME OF REGISTRAR <b>Robert E. Taylor, M.D.</b>	25C. FUNERAL DIRECTOR <b>Armaeast Funeral Chapel</b>	
		ADDRESS <b>4600 Liberty Hts</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

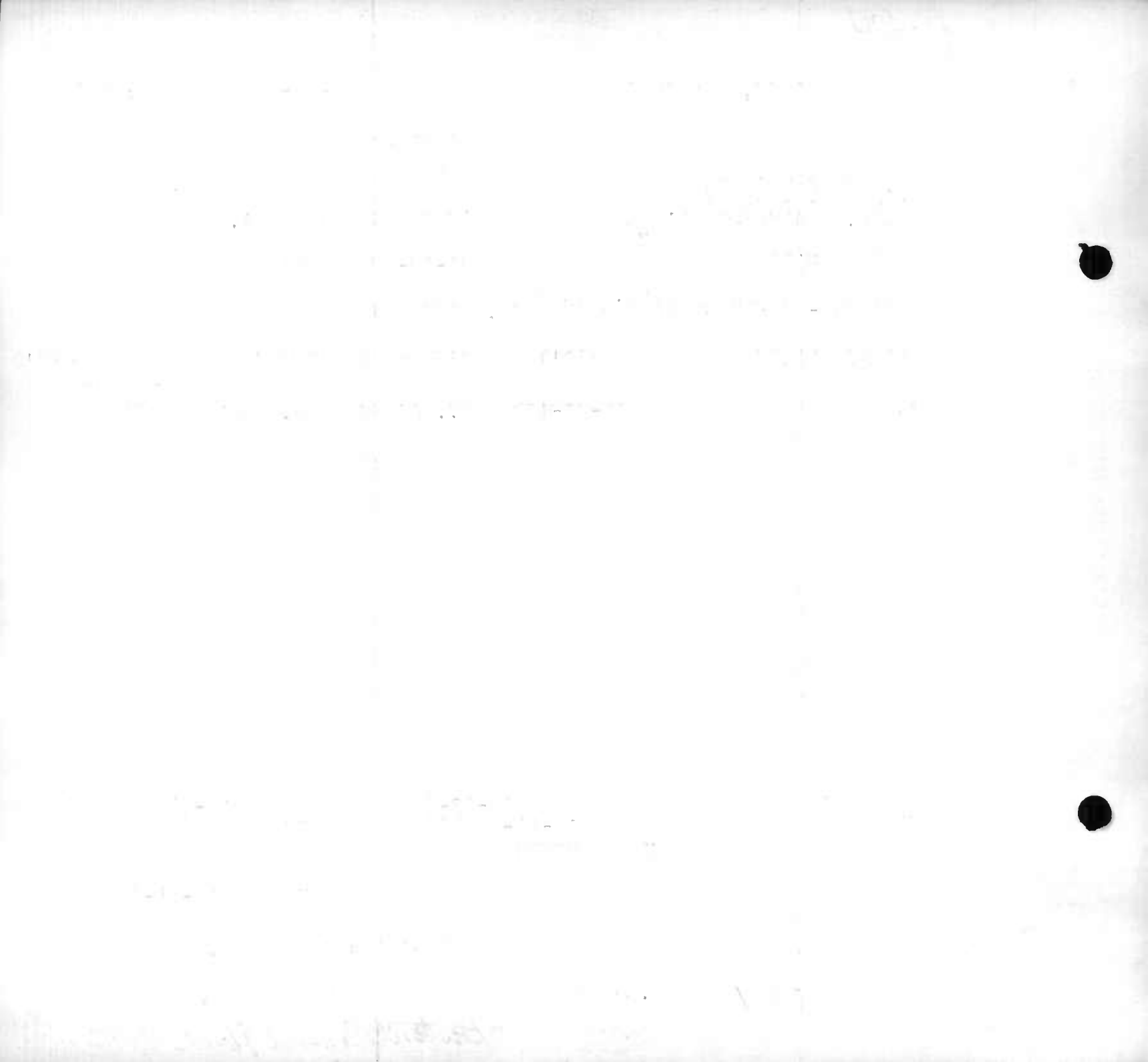
BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <span style="font-size: 2em;">X</span>	
69 12815		69 12815	
BIRTH NO. <span style="font-size: 2em;">R-252</span>			
1. NAME OF DECEASED (Type or Print) <span style="font-size: 1.2em;">EVA D. RZUNSA</span>		2. DATE AND HOUR OF DEATH <span style="font-size: 1.2em;">21 DEC 1969</span> <span style="font-size: 1.2em;">8:07 P. M.</span>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <span style="font-size: 1.2em;">LINCOLN PK. MICH. 48146</span> B. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION <span style="font-size: 1.2em;">THE JOHNS HOPKINS HOSPITAL</span> <span style="font-size: 2em;">33</span>		C. CITY OR TOWN <span style="font-size: 1.2em;">810 CHAMPAIGN ST.</span> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER		<span style="font-size: 2em;">V-19</span>	
5. SEX <span style="font-size: 1.2em;">F</span>	6. RACE <span style="font-size: 1.2em;">W</span>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <span style="font-size: 1.2em;">09/18/23</span>
9. AGE (In years lost birthday) <span style="font-size: 1.2em;">46</span>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">HOUSE WIFE</span>	
11. BIRTHPLACE (State or foreign country) <span style="font-size: 1.2em;">W. VA.</span>		12. CITIZEN OF WHAT COUNTRY? <span style="font-size: 1.2em;">USA</span>	
13. FATHER'S NAME <span style="font-size: 1.2em;">ELIAS E. CARTER</span>		14. MOTHER'S MAIDEN NAME <span style="font-size: 1.2em;">CECILIA V.</span>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <span style="font-size: 1.2em;">NO</span>		16. SOCIAL SECURITY NO. <span style="font-size: 1.2em;">290-12-8398</span>	
17. INFORMANT <span style="font-size: 1.2em;">KEN CARTER</span>		ADDRESS <span style="font-size: 1.2em;">613 DUNWICH WAY</span>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <span style="font-size: 1.2em;">410.9 I</span> (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <span style="font-size: 1.2em;">Myocardial Infarction</span>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <span style="font-size: 1.2em;">45 min</span>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <span style="font-size: 1.2em;">Arteriosclerotic Heart Disease</span> (B) DUE TO, OR AS A CONSEQUENCE OF: <span style="font-size: 1.2em;">Rheumatic Heart &amp; Valvular Disease</span> (C)	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			
19A. DATE OF OPERATION <span style="font-size: 1.2em;">2</span>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) <span style="font-size: 1.2em;">YES</span>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <span style="font-size: 1.2em;">YES</span>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <span style="font-size: 1.2em;">19</span> to <span style="font-size: 1.2em;">19</span> , that (I) (we) last saw the deceased alive on <span style="font-size: 1.2em;">19</span> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <span style="font-size: 1.2em;">Edward J. Dunn MD.</span>		23B. DATE SIGNED <span style="font-size: 1.2em;">21 Dec 1969</span>	
23C. PHYSICIAN'S NAME (Type) <span style="font-size: 1.2em;">Edward J. Dunn, M.D.</span>		23D. ADDRESS <span style="font-size: 1.2em;">The Johns Hopkins Hospital</span>	
24A. BURIAL CREMATION, REMOVAL (Specify) <span style="font-size: 1.2em;">REMOVAL</span>		24B. DATE <span style="font-size: 1.2em;">12/23/69</span>	
24C. NAME OF CEMETERY or CREMATORY <span style="font-size: 1.2em;">LINCOLN PARK</span>		24D. LOCATION (City, town, or county) (State) <span style="font-size: 1.2em;">LINCOLN PARK MICH.</span>	
25A. DATE REC'D BY HEALTH DEPT. <span style="font-size: 1.2em;">DEC 29 1969</span>		25B. NAME OF REGISTRAR <span style="font-size: 1.2em;">Robert E. Taylor MD.</span>	
25C. FUNERAL DIRECTOR <span style="font-size: 1.2em;">J. J. CONNELLY &amp; SONS</span>		ADDRESS <span style="font-size: 1.2em;">300 MACE</span>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				REG. NO. 69 12816	
BIRTH NO. 69 12816		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) BAILEY, LESLIE		2. DATE AND HOUR OF DEATH 12-24-69 8:00 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 2864			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) ST. AGNES HOSPITAL WILKENS & CATON AVE BALTO. MARYLAND 21228		C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX MALE 6. RACE WHITE 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 01-19-98		9. AGE (in years last birthday) 71	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED - CLERK		10B. KIND OF BUSINESS OR INDUSTRY Manager A. & P. Store & CANNON SHOE CO.		11. BIRTHPLACE (State or foreign country) MARYLAND	
13. FATHER'S NAME ALBERT BAILEY		14. MOTHER'S MAIDEN NAME CATHERINE (CAVEY)		12. CITIZEN OF WHAT COUNTRY? USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 217-01-1079		17. INFORMANT WILKENS & CATON ST. AGNES HOSP. RECORD ROOM	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH 492X1 I (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		CAUSE OF DEATH (A) IMMEDIATE CAUSE <i>Emphysema</i> DUE TO, OR AS A CONSEQUENCE OF: (B) <i>Cirrhosis</i> DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (X) (this hospital) attended the deceased from 12-23-69 19 9 to 12-24 1969 that (X) (we) last saw the deceased alive on 12-24- 19.69 and that (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (XXXXX) view the body after death.					
23A. SIGNATURE <i>Ching Hui Tsai</i>		23B. DATE SIGNED 12-24-69		23C. PHYSICIAN'S NAME (Type) CHING-HUI TSAI, M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/27/1969		24C. NAME OF CEMETERY OR CREMATORY St. Johns Cemetery	
25A. DATE REC'D BY HEALTH DEPT. DEC 29 1969		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR Easton Funeral Home - Catonsville, Md.	
24D. LOCATION (City, town, or county) (State) Ellicott City, Maryland					



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-640		69 12817		BALTIMORE CITY HEALTH DEPARTMENT		69 12817	
CERTIFICATE OF DEATH				REG. NO.			
1. NAME OF DECEASED (Type or Print)		JAMES J. BURRILL, SR.		2. DATE AND HOUR OF DEATH		DECEMBER 21, 1969 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION  00				A. STATE		B. COUNTY	
				Md.			
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  4202 WILLSHIRE AVE				C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
				BALTIMORE		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 4202 WILLSHIRE AVE.			
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years lost birthday)	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.
MALE	WHITE	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	JULY 12, 1896	73			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
RETIRED ENGINEER		PENNSYLVANIA R. R.		LURAY, VA.		U.S.A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
GEORGE BURRILL				LAURA BAKER			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
NO		A-77-01-8782		FAMILY		4202 WILLSHIRE AVE	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH			
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)				CARCINOMA OF JAW			
ANTECEDENT CAUSES				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO, OR AS A CONSEQUENCE OF:			
				(C) DUE TO, OR AS A CONSEQUENCE OF:			
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?		(If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from 1950 to 12/21 1969, that (I) (we) last saw the deceased alive on 12/21 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
J. E. Kassel, M.D.				12/21/69			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
				3501 ST. PAUL ST. BALTO., MD.			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
BURIAL		12-24-69		STABLERS UNITED METHODIST CHURCH CEMETERY		PARKTON, MD.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
DEC 29 1969		Robert E. Talbot, M.D.		J. Talbot		5444 BELAIR RD.	

502-108



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 69 12818	
W-362 69 12818		BALTIMORE CITY HEALTH DEPARTMENT	
BIRTH NO.		2. DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print) <i>Loretta M. Waters</i>		<i>Dec 22, 1969 11:50 P M.</i>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE B. COUNTY	
<i>09539 Upshire Rd</i>		<i>MD Baltimore</i>	
5. SEX <i>F</i>		6. RACE <i>W</i>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH	
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<i>10-13-1897</i>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		9. AGE (In years last birthday)	
<i>Housewife @ home</i>		<i>72</i>	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<i>Ind.</i>		<i>USA</i>	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
<i>James Morgan</i>		<i>Catherine</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
<i>NO</i>		<i>Wm L. Waters - Above</i>	
18. <i>410.0 I</i>		CAUSE OF DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		<i>4 hrs</i>	
ANTECEDENT CAUSES		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		<i>Myocardial infarction</i>	
		(B) <i>Hypertensive arteriosclerotic heart dis. 10 yrs</i>	
		(C) <i>Due to, or as a consequence of:</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
<i>0</i>		<i>no</i>	
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
<i>no</i>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
<input type="checkbox"/>			
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from <i>Jan 5 1964</i> to <i>Dec 22 1969</i> , that (I) (we) last saw the deceased alive on <i>Dec 22 1969</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE		23B. DATE SIGNED	
<i>Frederick J. Vollmer MD</i>		<i>Dec 24, 1969</i>	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS	
<i>FREDERICK J. VOLLMER MD</i>		<i>6100 York Rd Baltimore Md. 21212</i>	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE	
<i>Burial</i>		<i>12/26/69</i>	
24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
<i>New Cathedral</i>		<i>Baltimore Ind.</i>	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR	
<i>DEC 29 1969</i>		<i>Robert E. Taylor, M.D.</i>	
25C. FUNERAL DIRECTOR		ADDRESS	
<i>Shelton Benjamin</i>		<i>Sevinia Rd, Ind.</i>	

Letter to Mr. [illegible]

[Faint, illegible handwritten text]

[Faint, illegible handwritten text]

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

F-260		69 12819		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		REG. NO. 69 12819	
1. NAME OF DECEASED (Type or Print)		ANN MARIE Fisher				2. DATE AND HOUR OF DEATH Dec. 23, 1969 12 <sup>42</sup> 4 M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD						4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY MARYLAND 1100			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) UNIVERSITY of MARYLAND Hospital 38 BALTIMORE, MD.						C. CITY OR TOWN SEVERNA PARK		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX F						6. RACE CAUC.		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life. If retired) App. Handbresser						8. DATE OF BIRTH JAN 12-1950		9. AGE (in years last birthday) 19	
10B. KIND OF BUSINESS OR INDUSTRY						11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME DANIEL Fisher						14. MOTHER'S MAIDEN NAME Elizabeth Mitchell			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no						16. SOCIAL SECURITY NO.		17. INFORMANT Daniel S Fisher - Above	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH 567.0 I Aspiration pneumonia (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Secondary to ileus. Secondary to ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (B) DUE TO, OR AS A CONSEQUENCE OF: Right subphrenic abscess II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from Dec 19 19 69 to Dec 23 19 69 that (I) (we) lost saw the deceased alive on Dec 23 19 69 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE E. Shafii MD						23B. DATE SIGNED 12-23-69		23C. PHYSICIAN'S NAME (Type) E. Shafii MD	
24A. BURIAL CREMATION REMOVAL (Specify)		24B. DATE 12/27/69		24C. NAME OF CEMETERY or CREMATORY New Cathedral		24D. LOCATION (City, town, or county) (State) Baltimore and			
25A. DATE REC'D BY HEALTH DEPT. DEC 29 1969		25B. NAME OF REGISTRAR Robert E. Fisher		25C. FUNERAL DIRECTOR Robert E. Fisher		25D. ADDRESS Severna Park, Md			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

S-536		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 69 12820	
69 12820		CERTIFICATE OF DEATH			
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		SNYDER WILLIAM NEWMAN		December 25, 1969 5 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		A. STATE B. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		MARYLAND		1307	
44 UNION Memorial Hospital		C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER 1108 W 38TH STREET 21211			
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
MALE	WHITE		05-19-83	86	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Supervisor		Sealtest		MARYLAND	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY	
THOMAS F. SNYDER		ELIZA ELLEN DAVIDSON		U. S. A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No		216-10-8614		Mrs. Edwin Sneeringer-1108 W. 38th St.	
18. 412.3 I CAUSE OF DEATH		DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		Cerebrovascular Accident	
ANTECEDENT CAUSES		(B) DUE TO, OR AS A CONSEQUENCE OF:		Atherosclerotic Heart Disease	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		BRONCHOPNEUMONIA - Congest heart Failure			
19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
		NO			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from December 4 1969 to December 25 1969 that (I) (we) last saw the deceased alive on December 25 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Miguel Karacuschansky M.D.				23B. DATE SIGNED December 25, 1969	
23C. PHYSICIAN'S NAME (Type) MIGUEL KARACUSCHANSKY M.D.				23D. ADDRESS UNION Memorial Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)		
Burial	12/29/69	Wesley Chapel Cemetery	Carroll Co., Md.		
25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS		
DEC 29 1969	Robert E. Taylor M.D.	Agon Bonovian	3818 Roland Ave.		

Union Memorial Hospital

MALE WHITE

X

02-19-83

MARYLAND

ELISA ELLEN DAVENPORT

THOMAS F. SNYDER

Cerebrovascular Accident

Right-sided Hemiparesis

Left-sided Hemiparesis

NO

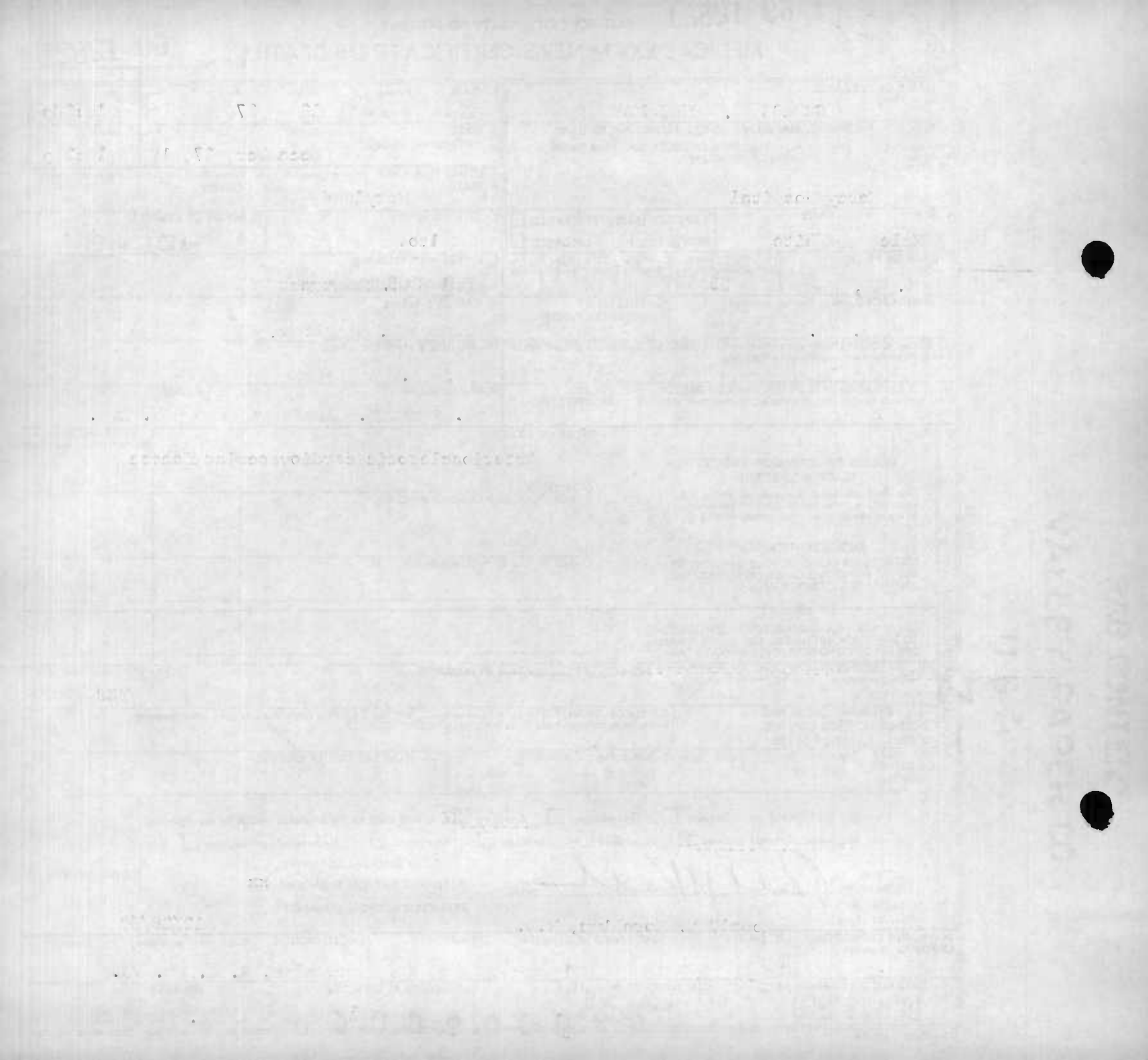
Examined 12-01

Staff Nurse

Miss KARRASINSKY, M.D.

Union Memorial Hospital

1. NAME OF DECEASED (Type or Print) <b>GEORGE C. HINKLEMAN</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> 12 27 69 10:28p M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>37 Mercy Hospital</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>December 27, 1969 10:28p M.</b>	
5. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b> C. CITY OR TOWN <b>Balto.</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			
6. SEX <b>Male</b>	7. RACE <b>White</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH <b>Oct. 31, 1916</b>	10. AGE (In years last birthday) <b>53</b>	11. BIRTHPLACE (State or foreign country) <b>Balto. Md.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>George L. Hinkleman</b>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Captain</b>		14B. KIND OF BUSINESS OR INDUSTRY <b>Tug Boat</b>	
15. MOTHER'S MAIDEN NAME <b>Rose M. Gaughran</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes # 2</b>	
17. SOCIAL SECURITY NO.		18. INFORMANT ADDRESS <b>Mrs. Agnes M. Hinkleman 246 5th. Ave.</b>	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <b>Arteriosclerotic cardiovascular disease</b> (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). II 20A. DATE OF OPERATION <b>12/28/69</b> 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED 21. AUTOPSY? (Yes or No) <b>YES</b>			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <b>Ronald N. Kornblum</b> M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) <b>Ronald N. Kornblum, M.D.</b> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <b>12/28/69</b> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12 31 1969</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Holy Cross</b>		24D. LOCATION (City, town, or county) (State) <b>Brooklyn, A. A. Co. Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 29 1969</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>	
25C. FUNERAL DIRECTOR <b>Mc Call</b>		ADDRESS <b>130 E. Fort Ave</b>	





BIRTH NO.

1. NAME OF DECEASED (Type or Print) AGOSTINO SAPIENZA		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year December 23, 1969		Hour M.
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 1734 Patapsco Street		3. DATE PRONOUNCED DEAD Month Day Year December 23, 1969		Hour 3:00 P.M.
6. SEX Male		7. RACE White	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH Jan. 1, 1878		10. AGE (In years lost birthday) 91	11. BIRTHPLACE (State or foreign country) Italy	
12. CITIZEN OF WHAT COUNTRY? U S A		13. FATHER'S NAME Frank Sapienza		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Owner-Store
15. MOTHER'S MAIDEN NAME Rosalie Unknown		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO.
18. INFORMANT Mr. Frank A. Sapienza		19. ADDRESS Burnie Md. S. E. Glen		20. CAUSE OF DEATH Arteriosclerotic cardiovascular disease

19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 412.4 I		20. CAUSE OF DEATH Arteriosclerotic cardiovascular disease		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
21. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
		(B) DUE TO, OR AS A CONSEQUENCE OF:			
		(C) DUE TO, OR AS A CONSEQUENCE OF:			
22. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					

20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No)	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	

23. I certify that I held an Inquiry ☒ Inspection ☐ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ ASSOCIATE MEDICAL EXAMINER ☐ DATE SIGNED December 26, 1969

24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 12 27 69	24C. NAME of CEMETERY or CREMATORY Holy Cross	24D. LOCATION (City, town, or county) (State) Brooklyn, A. A. Co. Md.
25A. DATE REC'D BY HEALTH DEPT. DEC 29 1969	25B. NAME OF REGISTRAR Robert E. Taylor	25C. FUNERAL DIRECTOR Mc Gully	ADDRESS 130 E. Fort Ave

ACADEMY ID 0000

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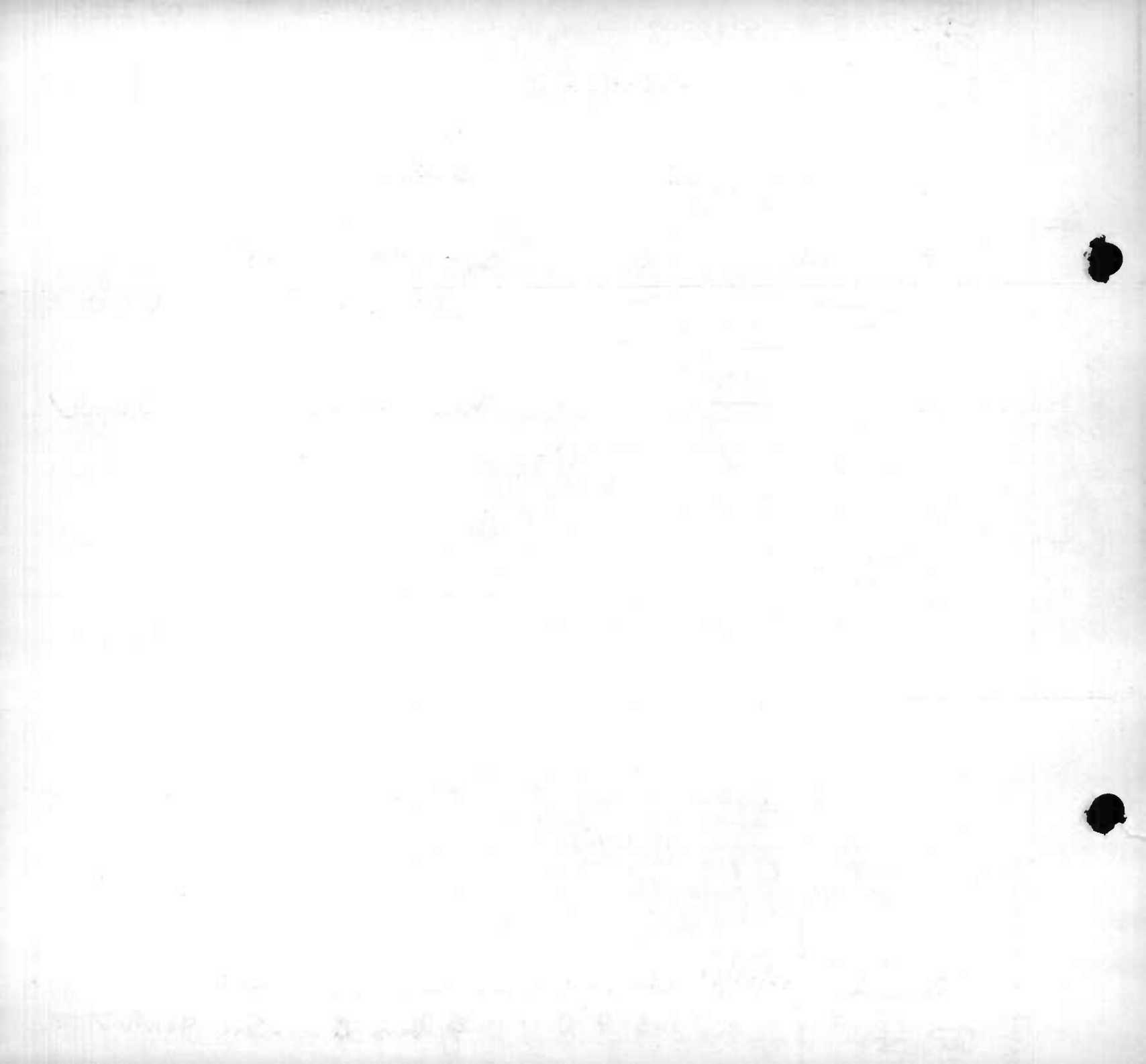
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# FUNERAL DIRECTOR: IMPORTANT

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Baltimore City Health Department				REG. NO.	
K-325		69 12823		69 12823	
1. NAME OF DECEASED (Type or Print) <b>JENNY KATZENSTEIN</b>		2. DATE AND HOUR OF DEATH <b>12/23/69 11 P.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>3901 Pinkney Road</b>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>md</b> B. COUNTY <b>2730</b>			
		C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER <b>3901 Pinkney Road</b>			
5. SEX <b>F</b>	6. RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Sept 4, 1981</b>	9. AGE (In years lost birthday) <b>88</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Germany</b>	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mrs Zea Kahn</b>	
				ADDRESS <b>Same</b>	
18. <b>412.3 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES  DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH <b>Cerebrovascular Accident</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>ASHD</b> (B) _____ DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 hr</b> <b>20 yrs</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>1955</b> to <b>12/23</b> 19 <b>69</b> , that (I) (we) last saw the deceased alive on <b>12/23</b> 19 <b>69</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Frou E. Kasel, MD</b>				23B. DATE SIGNED <b>12/24/69</b>	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12/24/69</b>		24C. NAME of CEMETERY or CREMATORY <b>Chesa Chaves Chesa</b>	
24D. LOCATION (City, town, or county) <b>Rosedale</b>		24E. LOCATION (State) <b>md</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 29 1969</b>		25B. NAME OF REGISTRAR <b>Robert E. Fisher, MD</b>		25C. FUNERAL DIRECTOR <b>Edmund Lewis &amp; Son</b>	
		25D. ADDRESS <b>9610 Reisterstown Rd</b>			



# FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>69 12824</u>
<b>B-625</b> <b>69 12824</b> <b>CERTIFICATE OF DEATH</b>		<b>BIRTH NO.</b> <b>1. NAME OF DECEASED</b> (Type or Print) <u>LEAH B. BRIGGEMAN</u>		
<b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b>  FULL NAME OF HOSPITAL OR INSTITUTION <u>BROADVIEW APTS.</u> <u>00 39TH STREET</u>		<b>2. DATE AND HOUR OF DEATH</b> <u>DEC. 22, 1969</u> M. <b>4. USUAL RESIDENCE</b> (Where deceased lived. If institution; residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>12-01</u> <b>C. CITY OR TOWN</b> <u>BALTIMORE</u> <b>D. INSIDE CITY LIMITS?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> <b>E. STREET AND NUMBER</b> <u>UNIV. PARKWAY + 39TH ST.</u>		
<b>5. SEX</b> <u>F</u>	<b>6. RACE</b> <u>W</u>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>JUNE 26, 1989</u>	
<b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>ACCOUNTANT/RET.</u>		<b>10B. KIND OF BUSINESS OR INDUSTRY</b> <u>DISTILLERY</u>		<b>9. AGE</b> (In years lost birthday) <u>80</u>
<b>11. BIRTHPLACE</b> (State or foreign country) <u>MD.</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>		
<b>13. FATHER'S NAME</b> <u>JACOB E. MILLER</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>ANNA V. BARTON</u>		
<b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		<b>16. SOCIAL SECURITY NO.</b> <u>—</u>		<b>17. INFORMANT</b> <u>Hollen E. Miller - 5309 4th. Albemarle Rd.</u>
<b>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>4/10/94 - 250.9</u> <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Arteriosclerotic heart disease</u>		<b>CAUSE OF DEATH</b> <b>(A) IMMEDIATE CAUSE</b> DUE TO, OR AS A CONSEQUENCE OF: <u>Myocardial infarction</u> <b>(B)</b> DUE TO, OR AS A CONSEQUENCE OF: <u>Arteriosclerotic heart disease</u> <b>(C)</b> <u>Diabetes mellitus</u>		<b>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</b> <u>Hours</u> <u>Years</u>
<b>II</b> <b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</b>				
<b>19A. DATE OF OPERATION</b> <u>0</u>		<b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b>		<b>20A. AUTOPSY?</b> (Yes or No)
<b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner) <input type="checkbox"/>		<b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		<b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)
<b>21D. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (Approx.)		<b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		<b>21F. HOW DID INJURY OCCUR?</b>
<b>22. I certify that (1) (this hospital) attended the deceased from <u>August</u>, 19 <u>68</u> to <u>December</u>, 19 <u>69</u>, that (1) (we) last saw the deceased alive on <u>Dec 15</u>, 19 <u>69</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.</b>				
<b>23A. SIGNATURE</b> <u>RK Country</u>		<b>23B. DATE SIGNED</b> <u>12-23-69</u>		<b>23C. PHYSICIAN'S NAME</b> (Type) <u>RICHARD K. GUNDRY, M.D.</u>
<b>24A. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>		<b>24B. DATE</b> <u>12-24-69</u>		<b>24C. NAME OF CEMETERY or CREMATORY</b> <u>Landon Park Cem.</u>
<b>24D. LOCATION</b> (City, town, or county) (State) <u>Baltimore</u> <u>Ind.</u>		<b>24E. FUNERAL DIRECTOR</b> <u>John E. Country</u>		
<b>25A. DATE REC'D BY HEALTH DEPT.</b> <u>DEC 29 1969</u>		<b>25B. NAME OF REGISTRAR</b> <u>Robert E. Farber, R.D.</u>		<b>25C. ADDRESS</b> <u>7 N. Calverly Ind.</u>

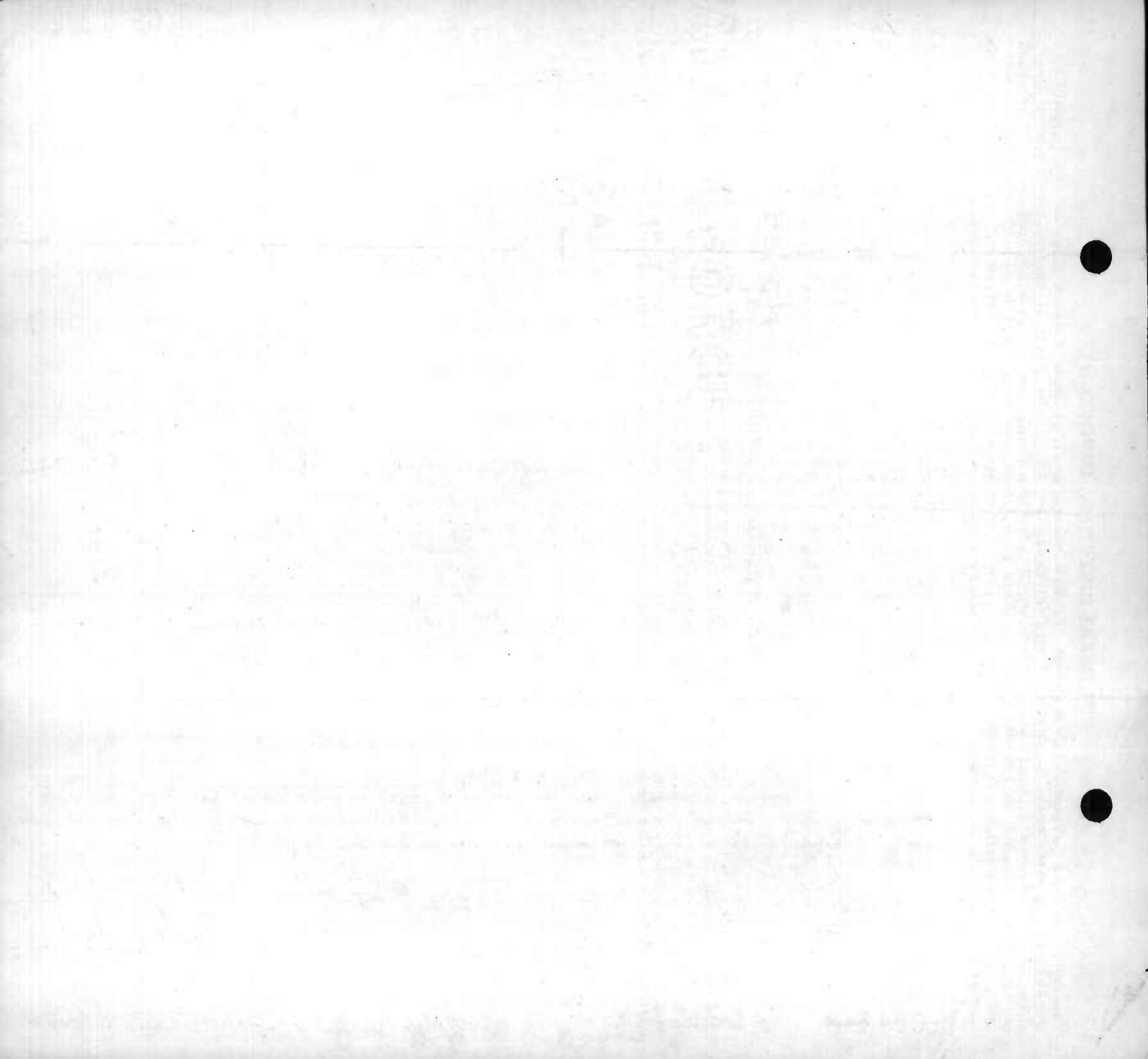


# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <b>69 12825</b>	
5-162 <b>69 12825</b>		<b>CERTIFICATE OF DEATH</b>	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>CARL B. SPRAGUE</b>	
2. DATE AND HOUR OF DEATH <b>DEC. 24, 1969 - 9 P</b>		M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION <b>90 ANDERSON NURSING HOME</b>		A. STATE <b>MD.</b> B. COUNTY <b>BALTO.</b> <b>53-00</b>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <b>CATONSVILLE</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <b>M</b> 6. RACE <b>W</b> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		E. STREET AND NUMBER <b>1015 PROSPECT</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>PROP. RET.</b>		8. DATE OF BIRTH <b>FEB. 2, 1913</b> 9. AGE (In years last birthday) <b>56</b>	
10B. KIND OF BUSINESS OR INDUSTRY <b>TAVERN</b>		11. BIRTHPLACE (State or foreign country) <b>MD.</b>	
13. FATHER'S NAME <b>NOT KNOWN</b>		12. CITIZEN OF WHAT COUNTRY?	
14. MOTHER'S MAIDEN NAME <b>NOT KNOWN</b>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>	
16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mrs. Von Schuly-4708 Landview 2208</b> ADDRESS	
18. <b>4123 I</b> CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>(1) - Intero. Sclerosis - Heart Disease - 5 yrs.</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <b>21 - Chronic Dephritis - 2 yrs.</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		(C) <b>Generalized Arterio-sclerosis</b>	
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) <b>No</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <b>Sept. 25 1968</b> to <b>Dec. 24 1969</b> , that (I) ( <del>was</del> ) last saw the deceased alive on <b>Dec. 23 1969</b> and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>we</del> ) ( <del>and</del> ) (did not) view the body after death.			
23A. SIGNATURE <b>Earl L. Chambers M.D.</b>		23B. DATE SIGNED <b>12/26/69</b>	
23C. PHYSICIAN'S NAME (Type) <b>Earl L. Chambers M.D.</b>		23D. ADDRESS <b>100 W. Bell Spring Lane Balto. Md.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12-26-69</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Woodlawn Cemetery</b>		24D. LOCATION (City, town, or county) <b>Woodlawn Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 29 1969</b>		25B. NAME OF REGISTRAR <b>Robert E. Fisher, M.D.</b>	
25C. FUNERAL DIRECTOR <b>Fisher &amp; Gough M.D. - Catonsville Md.</b>		ADDRESS	







This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

C-615		69 12826		BALTIMORE CITY HEALTH DEPT.		69 12826	
BIRTH NO.				REG. NO.			
1. NAME OF DECEASED (Type or Print) <b>Lydia Carpenter</b>				2. DATE AND HOUR OF DEATH <b>December 21, 1969 7<sup>30</sup> A.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>12-03</b>			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>The Seton Psychiatric Institution 6400 Wabash Avenue Baltimore, Maryland 21215</b>				C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <b>322 E. 28th Street 21218</b>							
5. SEX <b>Female</b>	6. RACE <b>Caucasian</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/>		8. DATE OF BIRTH <b>7-4-95</b>	9. AGE (In years last birthday) <b>74</b>	10. Under 1 Yr. Months: Days: Hours: Min.	11. Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>File Clerk</b>				10B. KIND OF BUSINESS OR INDUSTRY <b>Federal Reserve Bank</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Henry M. Bowers</b>				14. MOTHER'S MAIDEN NAME <b>Marie Conelius</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>unknown</b>				16. SOCIAL SECURITY NO. <b>219-30-7497</b>		17. INFORMANT ADDRESS <b>Mr. Thomas Crayton, 951 Northwood St. D.C.</b>	
18. <b>437.9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) IMMEDIATE CAUSE <b>Pneumonitis, left lung</b> DUE TO, OR AS A CONSEQUENCE OF: (B) <b>General and cerebral arteriosclerosis</b> DUE TO, OR AS A CONSEQUENCE OF: (C) <b>Urinary tract infection (Proteus)</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b> <b>about 8 yrs.</b> <b>10 weeks</b> <b>6 yrs.</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				<b>Chronic brain syndrome with cerebral arteriosclerosis</b>			
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <input checked="" type="checkbox"/>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>April 24, 1969</b> to <b>December 21, 1969</b> , that (I) (we) last saw the deceased alive on <b>December 21, 1969</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Walter O. Jahrreiss M.D.</b>				23B. DATE SIGNED <b>Dec. 21, 1969</b>			
23C. PHYSICIAN'S NAME (Type) <b>Dr. Walter O. Jahrreiss</b>				23D. ADDRESS <b>6400 Wabash Avenue Balto. Md.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12-24-69</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Cathedral Cem.</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore Ind</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 29 1969</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR <b>James J. Cavanaugh - Cavanaugh</b>		25D. ADDRESS	



# FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>69 12827</u>
<b>BIRTH NO.</b> <b>1. NAME OF DECEASED</b> (Type or Print) <u>KASPER, ALFRED A</u>		<b>2. DATE AND HOUR OF DEATH</b> <u>12/24/69</u> <u>10<sup>35</sup> P. M.</u>		
<b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b>  <b>FULL NAME OF HOSPITAL OR INSTITUTION</b> (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>ST. AGNES HOSP.</u> <u>BALTO., MD., 21229</u>		<b>4. USUAL RESIDENCE</b> (Where deceased lived, if institution; residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>BALTO.</u> <b>C. CITY OR TOWN</b> <u>BALTO.</u> <b>D. INSIDE CITY LIMITS?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <b>E. STREET AND NUMBER</b> <u>5502 Medwick Garth</u>		
<b>5. SEX</b> <u>M</u>	<b>6. RACE</b> <u>W</u>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>8/23/12</u> <b>9. AGE (In years last birthday)</b> <u>57</u> <b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>SHIP FITTER</u> <b>11. BIRTHPLACE</b> (State or foreign country) <u>MD.</u> <b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>	
<b>13. FATHER'S NAME</b> <u>NOT KNOWN</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>NOT KNOWN</u>		
<b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		<b>16. SOCIAL SECURITY NO.</b> <b>17. INFORMANT</b> <u>Mr. Alfred A. Kasper 5502 Medwick Garth</u> <b>ADDRESS</b>		
<b>18. CAUSE OF DEATH</b> <b>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II <b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).</b>				
<b>19A. DATE OF OPERATION</b> <u>0</u>		<b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b> <b>20A. AUTOPSY?</b> (Yes or No) <input type="checkbox"/> <b>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</b>		
<b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (Notify medical examiner) <input type="checkbox"/>		<b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)		
<b>21D. TIME OF INJURY (APPROX.)</b> (Month) (Day) (Year) (Hour)		<b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		
<b>22. I certify that (I) (this hospital) attended the deceased from</b> <u>12/24 9pm</u> <b>19</b> <u>69</u> <b>to</b> <u>12/24 (10<sup>35</sup>pm)</u> <b>19</b> <u>69</u> <b>that (I) (we) last saw the deceased alive on</b> <u>19</u> <b>and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</b>				
<b>23A. SIGNATURE</b> <u>Bizhan Ebrahimi MD.</u>		<b>23B. PHYSICIAN'S NAME (Type)</b> <u>BIZHANE BRAHIMY</u>		<b>23C. DATE SIGNED</b> <u>12/25/69</u>
<b>23D. ADDRESS</b> <u>ST. AGNES HOSP.</u>		<b>24A. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>		
<b>24B. DATE</b> <u>12-29-69</u>		<b>24C. NAME OF CEMETERY OR CREMATORY</b> <u>Golden Park Cemetery</u>		
<b>24D. LOCATION</b> (City, town, or county) (State) <u>Baltimore Md.</u>		<b>25A. DATE REC'D BY HEALTH DEPT.</b> <u>DEC 29 1969</u>		
<b>25B. NAME OF REGISTRAR</b> <u>Robert E. Taylor</u>		<b>25C. FUNERAL DIRECTOR</b> <u>John G. Catorville, Md.</u>		



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

J-200		69 12828		BALTIMORE CITY HEALTH DEPARTMENT		X		REG. NO. 69 12828	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>ROSE JACKIE</b>				2. DATE AND HOUR OF DEATH <b>12/24/69 1645</b> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD						4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <b>ST. AGNES HOSP.</b>						A. STATE <b>MD</b> B. COUNTY <b>BALTIMORE</b>			
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>40 BALTIMORE MD.</b>						C. CITY OR TOWN <b>CATONSVILLE</b>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <b>F</b> 6. RACE <b>W</b> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>						8. DATE OF BIRTH <b>AUG. 14, 1892</b>		9. AGE (In years last birthday) <b>77</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SEAMSTRESS</b>						10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>MD.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>									
13. FATHER'S NAME <b>CHRISTIAN JACKIE</b>						14. MOTHER'S MAIDEN NAME <b>KATE WEDDEN</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>						16. SOCIAL SECURITY NO. <b>A 216-05-6133</b>		17. INFORMANT ADDRESS <b>EMMA JACKIE 24 Shady Nook Ave.</b>	
18. <b>412.3 I</b> CAUSE OF DEATH						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH						(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>A.C.U.T.D</b>			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)						(B) <b>Coronary occlusion 1951 &amp; diffuse myocardial damage</b>			
ANTECEDENT CAUSES						(C) _____			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.									
II									
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).									
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At <input type="checkbox"/> Net While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <b>10-31</b> <b>1967</b> to <b>12-24</b> <b>1969</b> , that (I) ( <del>we</del> ) last saw the deceased alive on <b>11-25</b> <b>1969</b> and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>we</del> ) ( <del>did not</del> ) view the body after death.									
23A. SIGNATURE <b>John F. Schaefer MD</b>						23B. DATE SIGNED <b>12/26/69</b>			
23C. PHYSICIAN'S NAME (Type) <b>JOHN F. SCHAEFER MD</b>						23D. ADDRESS <b>401 RANDOM RD. BALTO. MD. 21229</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>12/29/69</b>		24C. NAME OF CEMETERY OR CREMATORY <b>WOODLAWN CEM</b>		24D. LOCATION (City, town, or county) (State) <b>BALTO. CO WOODLAWN MD</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 29 1969</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor MD</b>		25C. FUNERAL DIRECTOR <b>ES MacNabb</b>		25D. ADDRESS <b>301 Trevelick Rd Balto MD.</b>			

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<div style="display: flex; justify-content: space-between;"> <span>K-252</span> <span>69 12829</span> </div>		BALTIMORE CITY HEALTH DEPARTMENT <b>CERTIFICATE OF DEATH</b>		REG. NO. <span style="font-size: 1.5em;">69 12829</span>	
BIRTH NO. _____ 1. NAME OF DECEASED (Type or Print) <span style="font-size: 1.2em;">Bernard Kosnik</span>		2. DATE AND HOUR OF DEATH <span style="font-size: 1.2em;">Dec. 23, 1969 10:30 P.M.</span>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION <span style="font-size: 1.5em;">31</span> <span style="margin-left: 20px;">(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)</span> <span style="font-size: 1.2em;">Baltimore City Hospital</span> <span style="font-size: 1.2em;">4940 Eastern Avenue</span> <span style="font-size: 1.2em;">Baltimore, Maryland 21224</span>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <span style="font-size: 1.2em;">Maryland</span> B. COUNTY <span style="font-size: 1.2em;">BALTO. CO.</span> C. CITY OR TOWN <span style="font-size: 1.2em;">Baltimore</span> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <span style="font-size: 1.2em;">1617 Weyburn Road, Balto. Md. 21237</span>			
5. SEX <span style="font-size: 1.2em;">Male</span>	6. RACE <span style="font-size: 1.2em;">White</span>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <span style="font-size: 1.2em;">7-12-14</span>	9. AGE (In years last birthday) <span style="font-size: 1.2em;">55</span>	If Under 1 Yr. Months: _____ Days: _____ If Under 24 Hrs. Hours: _____ Min: _____
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">Sheet Metal Worker</span>		10B. KIND OF BUSINESS OR INDUSTRY <span style="font-size: 1.2em;">Band &amp; Logo</span>		11. BIRTHPLACE (State or foreign country) <span style="font-size: 1.2em;">Maryland</span>	
12. CITIZEN OF WHAT COUNTRY? <span style="font-size: 1.2em;">United States</span>		13. FATHER'S NAME <span style="font-size: 1.2em;">Anthony</span>			
14. MOTHER'S MAIDEN NAME <span style="font-size: 1.2em;">Frances</span>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <span style="font-size: 1.2em;">NO</span>			
16. SOCIAL SECURITY NO. _____		17. INFORMANT <span style="font-size: 1.2em;">BCH Records L</span> ADDRESS <span style="font-size: 1.2em;">4940 Eastern Avenue Baltimore, Md. 21224</span>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH <span style="font-size: 1.2em;">Possible Pulm. Embolism</span> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <span style="font-size: 1.2em;">M.I.</span> (B) DUE TO, OR AS A CONSEQUENCE OF: <span style="font-size: 1.2em;">Reticulum Cell Sarcoma</span> (C) <span style="font-size: 1.2em;">Atherosclerotic Cardiovasc. Dis.</span>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <span style="font-size: 1.2em;">Sec → min</span> <span style="font-size: 1.2em;">4 mo</span> <span style="font-size: 1.2em;">5 yr</span> <span style="font-size: 1.2em;">6 mo</span>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <span style="font-size: 1.2em;">Compens pos. hemolytic anemia. 6 mo.</span>					
19A. DATE OF OPERATION <span style="font-size: 1.2em;">2</span>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED _____		20A. AUTOPSY? (Yes or No) <span style="font-size: 1.2em;">Yes</span>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <span style="font-size: 1.2em;">YES</span>		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH? (Notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) _____			
21D. TIME OF INJURY (APPROX.) _____		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? _____	
22. I certify that (I) (this hospital) attended the deceased from <span style="font-size: 1.2em;">11-4</span> 19 <span style="font-size: 1.2em;">69</span> to <span style="font-size: 1.2em;">12-23</span> 19 <span style="font-size: 1.2em;">69</span> that (I) (we) last saw the deceased alive on <span style="font-size: 1.2em;">12-23</span> 19 <span style="font-size: 1.2em;">69</span> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <span style="font-size: 1.5em;">Paul Redstone</span>		23B. DATE SIGNED <span style="font-size: 1.2em;">12-23-69</span>		23C. PHYSICIAN'S NAME (Type) <span style="font-size: 1.2em;">Paul Redstone, M.D.</span>	
23D. ADDRESS <span style="font-size: 1.2em;">Baltimore City Hospital</span> <span style="font-size: 1.2em;">4940 Eastern Ave., Balto., Md 21224</span>		24A. BURIAL CREMATION, REMOVAL (Specify) <span style="font-size: 1.2em;">Burial</span>			
24B. DATE <span style="font-size: 1.2em;">12-26-69</span>		24C. NAME of CEMETERY or CREMATORY <span style="font-size: 1.2em;">Meadowridge Cem</span>		24D. LOCATION (City, town, or county) (State) <span style="font-size: 1.2em;">Elkridge, Md.</span>	
25A. DATE REC'D BY HEALTH DEPT. <span style="font-size: 1.2em;">DEC 29 1969</span>		25B. NAME OF REGISTRAR <span style="font-size: 1.2em;">Robert E. Talley, MD.</span>		25C. FUNERAL DIRECTOR <span style="font-size: 1.2em;">John H. Neph, 4200 Pennington Ave</span>	





FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <b>69 12830</b>	
69 12830		CERTIFICATE OF DEATH	
BIRTH NO. <b>11-400</b>		1. NAME OF DECEASED (Type or Print) <b>Charles Miller</b>	
2. DATE AND HOUR OF DEATH <b>December 23, 1969</b>		2:30 PM	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>The Johns Hopkins Hospital</b> ADDRESS OR LOCATION <b>Baltimore, Maryland, 21205</b>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>Baltimore</b> C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER <b>408 WALCOTT RD.</b>	
5. SEX <b>MALE</b>	6. RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan 18 1935</b> 9. AGE (In years last birthday) <b>34</b> If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Maintenance man</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Housing Authority</b>	
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>CHARLES M. MILLER SR.</b>		14. MOTHER'S MAIDEN NAME <b>LIDA WILLIAMSON</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>218 10 5866</b>	
17. INFORMANT <b>RUTH B. WOODS</b>		ADDRESS <b>21206 408 Walcott Road</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Aspiration</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Cerebrovascular accident</b>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Aspiration</b> (B) <b>Cerebrovascular accident</b> DUE TO, OR AS A CONSEQUENCE OF: (C) _____	
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 hour</b>			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>Resected urethral carcinoma</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 years</b>	
19A. DATE OF OPERATION <b>2 none</b>	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>xxx</b>	20A. AUTOPSY? (Yes or No) <b>yes</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <b>no</b>	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>xxx</b>	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>xxx</b>	
21D. TIME OF INJURY (Approx.) <b>xxx</b>	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>	21F. HOW DID INJURY OCCUR? <b>xxx</b>	
22. I certify that (this hospital) attended the deceased from <b>November 29, 19 69</b> to <b>December 23, 19 69</b> , that (I) <b>(we)</b> lost saw the deceased alive on <b>December 23, 19 69</b> and that in (my) <b>last</b> opinion death occurred on the date and hour and from the causes stated above. (I) <b>(we)</b> (did) (did not) view the body after death.			
23A. SIGNATURE <b>George H. Sack, Jr.</b>		23B. DATE SIGNED <b>12/23/69</b>	
23C. PHYSICIAN'S NAME (Type) <b>George H. Sack, Jr., M.D.</b>		23D. ADDRESS <b>601 N. Broadway, Baltimore, Md., 21205</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>12-28-1969</b>	24C. NAME OF CEMETERY or CREMATORY <b>Moreland Park Cemetery</b>	24D. LOCATION (City, town, or county) (State) <b>Baltimore M</b>
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 29 1969</b>		25B. NAME OF REGISTRAR <b>James E. Jackson</b>	
25C. FUNERAL DIRECTOR <b>Lassahn Funeral Home</b>		ADDRESS <b>7401 Belair Road</b>	

VS 153 1-6-70  
M.H.

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

C-436 69 12831		BALTIMORE CITY HEALTH DEPARTMENT		X		REG. NO. 69 12831	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Frieda P. Caltrider</i>		2. DATE AND HOUR OF DEATH <i>22 Dec 69 2:40</i> P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>MD</i> B. COUNTY <i>Baltimore Co</i>		C. CITY OR TOWN <i>Owings Mills</i>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION <i>The Union Memorial Hospital</i>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		E. STREET AND NUMBER <i>13 Bradburg Road</i>			
5. SEX <i>F</i>	6. RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>11-10-08</i>	9. AGE (In years last birthday) <i>61</i>	10. Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>MD</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Thomas Purdum</i>		14. MOTHER'S MAIDEN NAME <i>Frieda Wessel</i>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>216-46-2950</i>		17. INFORMANT <i>Hospital Chart</i>		ADDRESS	
18. <i>486 X I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <i>This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.</i>		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <i>Pneumonia and severe bilateral pulm.</i> DUE TO, OR AS A CONSEQUENCE OF: <i>emphysema</i>				(C) <i>M.M.O.</i>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION <i>2</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>Yes</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>12-19-69</i> to <i>12-22-1969</i> that (I) (we) last saw the deceased alive on <i>12-22-19-69</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>M. Cepeda M.D.</i>		DEGREE		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>22 Dec 69</i>	
23C. PHYSICIAN'S NAME (Type) <i>M. CEPEDA, M.D.</i>		DEGREE		23D. ADDRESS <i>Union Mem. Hosp. BALTO MD. 21218</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Cremation</i>		24B. DATE <i>12/26/69</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Fort Lincoln Cemetery</i>		24D. LOCATION (City, town, or county) (State) <i>Washington 18, D.C.</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>DEC 29 1969</i>		25B. NAME OF REGISTRAR <i>Robert E. Taylor, R.D.</i>		25C. FUNERAL DIRECTOR <i>H. J. Eichhardt</i>		ADDRESS <i>Owings Mills, Md.</i>	

1. CODE A, B, C.

MIN. F. L. E. J. L. C. P. A. B. C. D. E. F. G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z.

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
G-300 69 12832					REG. NO. 69 12832				
BIRTH NO.					1. NAME OF DECEASED (Type or Print)				
					GOOD, JOSEPH				
2. DATE AND HOUR OF DEATH					12/24/69 12.30 A.M.				
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD					4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)					A. STATE B. COUNTY				
SINAI HOSPITAL OF BALTIMORE					MARYLAND				
42					C. CITY OR TOWN D. INSIDE CITY LIMITS?				
					BALTIMORE YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
E. STREET AND NUMBER					107, CLAREN DON ROAD				
5. SEX		6. RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (in years lost birthday)	
M		W		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		12/30/08		62 yrs	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)					10B. KIND OF BUSINESS OR INDUSTRY				
Salesman									
11. BIRTHPLACE (State or foreign country)					12. CITIZEN OF WHAT COUNTRY?				
Pennsylvania					U.S.A.				
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME				
Joseph Good					Jeanette				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)					16. SOCIAL SECURITY NO.				
No									
17. INFORMANT					ADDRESS				
Hospital Records									
18. CAUSE OF DEATH					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
436.91 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH									
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)					(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:				
					CEREBROVASCULAR ACCIDENT				
ANTECEDENT CAUSES					(B) DUE TO, OR AS A CONSEQUENCE OF:				
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					GENERALIZED ARTERIOSCLEROSIS				
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					MYOCARDIAL INFARCTION, ATHEROSCLEROSIS, GANGRENE OF TOE				
19A. DATE OF OPERATION					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				
20A. AUTOPSY? (Yes or No)					20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
NO									
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)					21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				
					21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.)					21E. INJURY OCCURRED				
(Month) (Day) (Year) (Hour)					While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				
21F. HOW DID INJURY OCCUR?									
22. I certify that (I) (this hospital) attended the deceased from 11/25/69 to 12/24/69 that (I) (we) lost saw the deceased alive on 12/24/69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE					23B. DATE SIGNED				
Neelam Kapoor M.D. 9088					12/24/69				
23C. PHYSICIAN'S NAME (Type)					23D. ADDRESS				
Dr. NEELAM KAPOOR									
24A. BURIAL CREMATION, REMOVAL (Specify)					24B. DATE				
Burial					Dec. 29, 1969				
24C. NAME OF CEMETERY OR CREMATORY					24D. LOCATION (City, town, or county) (State)				
Northwood Cem.					Philadelphia, PA.				
25A. DATE REC'D BY HEALTH DEPT.					25B. NAME OF REGISTRAR				
DEC 29 1969					Robert S. Taylor, M.D.				
25C. FUNERAL DIRECTOR					ADDRESS				
J. J. Ellhardt					Owings Mills, Md.				

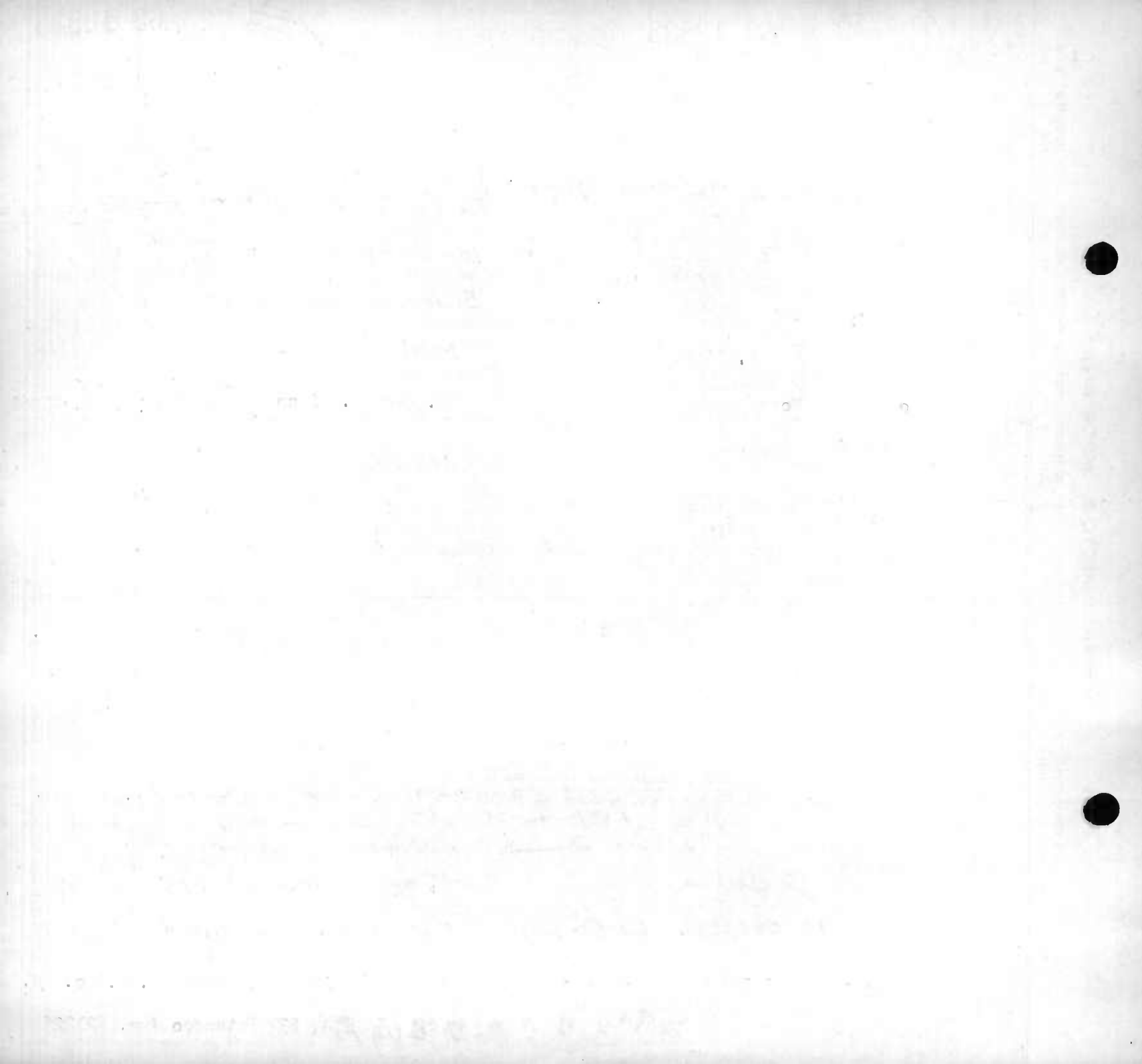
[REDACTED]



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

D-250		69 12833		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		REG. NO. 69 12833	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) ROBERT JAMES DIXON				2. DATE AND HOUR OF DEATH 12-25-69 1:00 P. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) South Baltimore General Hospital						4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY A.A.C. 52-00 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER Box 656 Midland Rd Rt 2 Glen Burnie			
5. SEX male	6. RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10-3-96		9. AGE (In years last birthday) 73		If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist				10B. KIND OF BUSINESS OR INDUSTRY ARUNDEL CORPORATION		11. BIRTHPLACE (State or foreign country) Baltimore Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME ROBERT E. Dixon				14. MOTHER'S MAIDEN NAME MARY McNamee					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) None				16. SOCIAL SECURITY NO. 214-01-2123		17. INFORMANT Mrs. Mary A. Dixon		ADDRESS Box 656 Route 2 Glen Burnie, Md. 21061	
18. 162.1 I		CAUSE OF DEATH						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: CANCER LUNGS							
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF:							
(C) _____									
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).									
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, form, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (H) (this hospital) attended the deceased from 8:40 PM 12-5-1969 to 1:00 P-12-25-1969, that (H) (we) lost saw the deceased olive on 1:00 PM 12-25-1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (H) (We) (did) (did not) view the body after death.									
23A. SIGNATURE Cecilia						DEGREE		23B. DATE SIGNED 12-25-69	
23C. PHYSICIAN'S NAME (Type) DR CECILIA CHEN MD						DEGREE		23D. ADDRESS 3001 S. Hanover street Balt Md	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/30/69		24C. NAME of CEMETERY or CREMATORY Cedar Hill Cemetery		24D. LOCATION (City, town, or county) (State) Ritchie Highway A. A. Co. Md.			
25A. DATE REC'D BY HEALTH DEPT. DEC 29 1969		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR B. Cally		ADDRESS 237 Patapsco Ave. 21225			

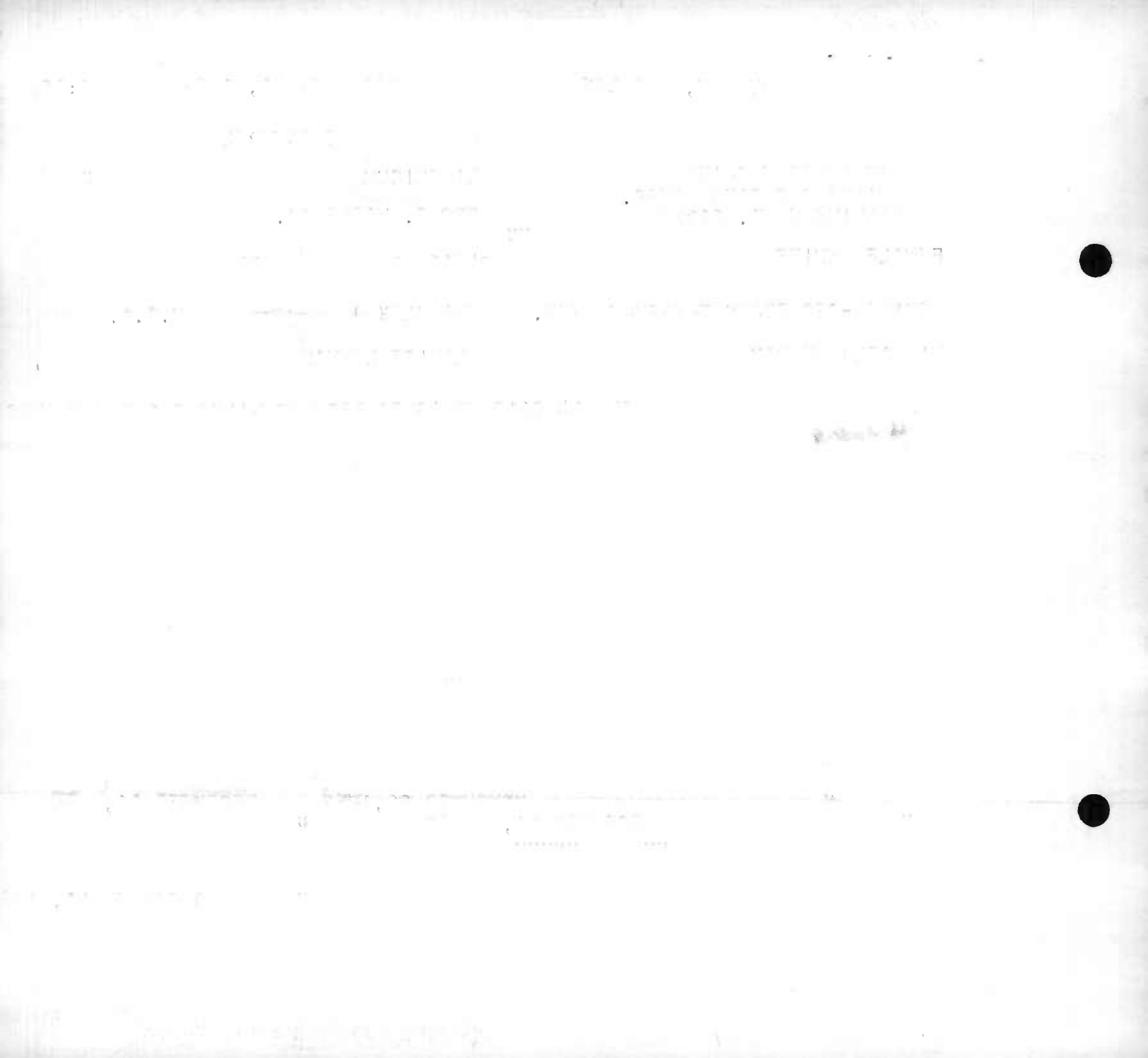




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

M-600		69 12834		BALTIMORE CITY HEALTH DEPARTMENT		69 12834	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH		REG. NO.	
		MURRAY, ORA LEE		DECEMBER 21, 1969		5:15 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)		A. STATE		B. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		MD		ANNE ARUNDEL		52-00	
ST AGNES HOSPITAL WILKENS & CATON AVES. BALTIMORE MD. 21229		C. CITY OR TOWN LINTHICUM		D. INSIDE CITY LIMITS?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
E. STREET AND NUMBER		720 E. MAPLE RD.					
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. If Under 1 Yr. Months	11. If Under 24 Hrs. Days	12. If Under 24 Hrs. Hours
FEMALE	WHITE	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	04/13/92	77			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
RETIRED-SECRETARY		TREASURY DEPT.		MARYLAND		U.S.A.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME					
WINFIELD MURRAY		LOUISE LOWMAN					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
NO		578 34 0110		0 ST AGNES RECORDS WILKENS & CATON AVES			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		anemia, terminal.			
ANTECEDENT CAUSES		(B) DUE TO, OR AS A CONSEQUENCE OF:					
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) DUE TO, OR AS A CONSEQUENCE OF:					
II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
0				NO			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (X) (this hospital) attended the deceased from		NOVEMBER 22, 1969		to		DECEMBER 21, 1969	
that (X) (we) last saw the deceased alive on		DECEMBER 21, 1969		and that in (X) (our) opinion death occurred on the date			
and hour and from the causes stated above, (X) (we) (did) (X) (X) (X) view the body after death.							
23A. SIGNATURE		23B. DATE SIGNED					
Ching Hui Tsai, M.D.		DECEMBER 21, 1969					
23C. PHYSICIAN'S NAME (Typel)		23D. ADDRESS					
CHING-HUI TSAI, M.D.		St Agnes Hospital					
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		Dec 24, 69		Epiphany Cemetery		Odenton, AA Co., Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
DEC 29 1969		Robert E. Taylor, M.D.		KIRK LEE FUNERAL HOME		Glen Burnie	



# FUNERAL DIRECTOR: IMPORTANT

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<div style="display: flex; justify-content: space-between;"> <span><b>G-435</b></span> <span><b>69 12835</b></span> <span>BALTIMORE CITY HEALTH DEPARTMENT</span> </div> <div style="display: flex; justify-content: space-between;"> <span><b>CERTIFICATE OF DEATH</b></span> <span>REG. NO. <b>69 12835</b></span> </div>					
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>Savina Goldman</b>		2. DATE AND HOUR OF DEATH <b>12/20/69 12:15 PM</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>14-01</b>		5. CITY OR TOWN <b>Baltimore</b>	
FULL NAME OF HOSPITAL OR INSTITUTION <b>The Gundry Sanitarium Inc.</b>		C. CITY OR TOWN		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		E. STREET AND NUMBER <b>1827 Bolton St.</b>			
5. SEX <b>Female</b>	6. RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 5, 1872</b>		9. AGE (in years) lost birthday <b>97</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Never worked</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>Louis Goldman</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
15. Was Deceased Ever in U. S. Armed Forces? <b>No</b> (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>216-46-6965</b>		17. INFORMANT <b>Father, deceased</b>	
18. <b>412.1 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oslenio, etc. It means the disease, injury or complication which caused death.) <b>ASCVD</b>		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>weeks</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) sloting the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Uremia</b>		<b>years</b>	
		(B) <b>nephrosclerosis</b> DUE TO, OR AS A CONSEQUENCE OF:		<b>years</b>	
		(C) _____		<b>years</b>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <b>D</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (H) (this hospital) attended the deceased from <b>July 25-1969</b> to <b>Dec 20 1969</b> , that (H) (we) last saw the deceased alive on <b>12/20 19 69</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) ( <del>did not</del> ) view the body after death.					
23A. SIGNATURE <b>J. Raymond Gladue</b>				23B. DATE SIGNED <b>12/20/69</b>	
23C. PHYSICIAN'S NAME (Type) <b>J. Raymond Gladue</b>				23D. ADDRESS <b>701 Brookwood Rd, Balt. 29, Md.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>12-24-69</b>		24C. NAME OF CEMETERY or CREMATORY <b>BALTO. HEBREW Cong. BALTO. MD.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 29 1969</b>		25B. NAME OF REGISTRAR <b>James E. ...</b>		25C. FUNERAL DIRECTOR <b>SONDHEIM F.H. BALTO. MD.</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

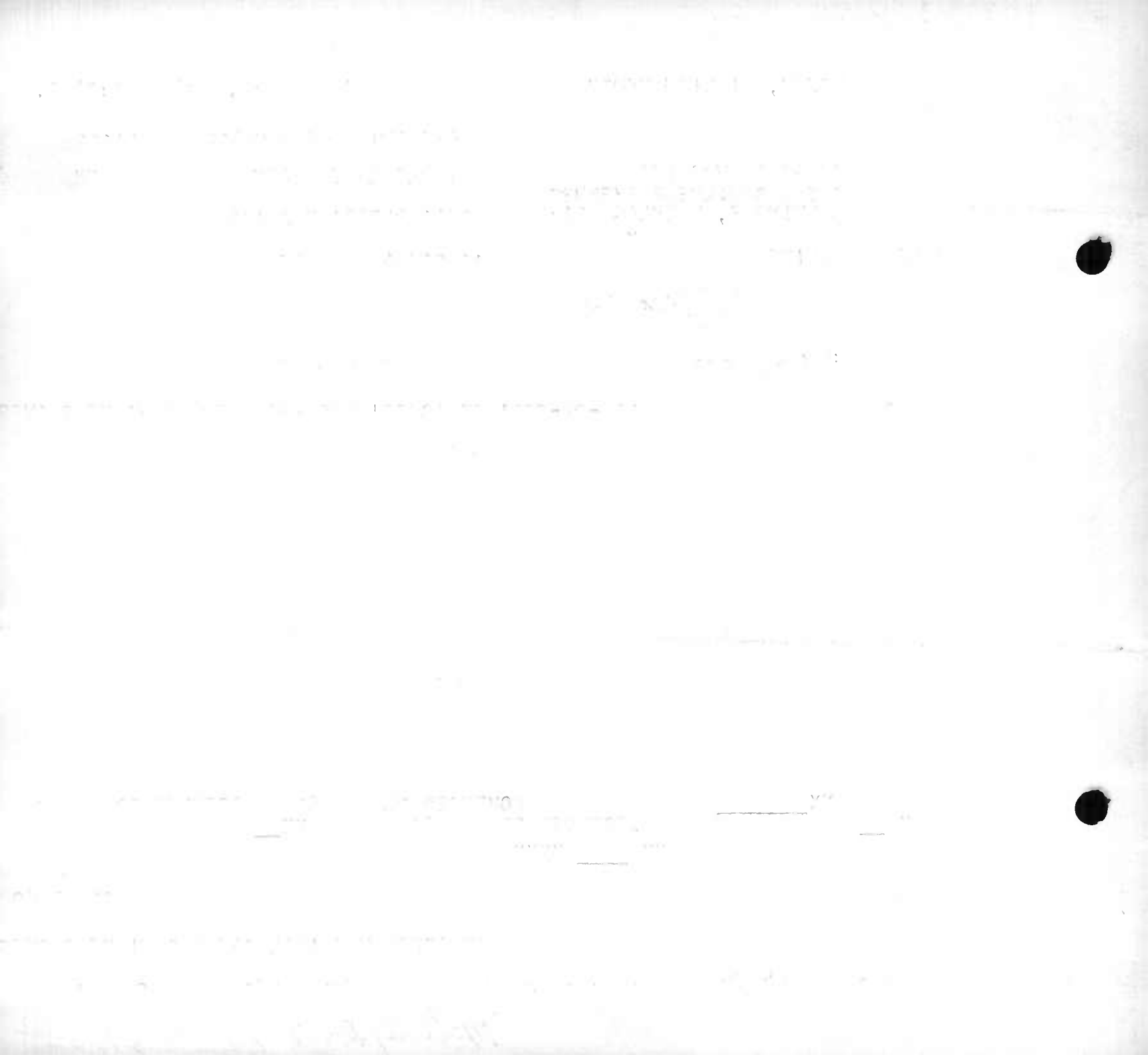
L-200		BIRTH NO. 69 12836		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 69 12836	
1. NAME OF DECEASED (Type or Print) <b>EMIL LEES</b>				2. DATE AND HOUR OF DEATH <b>12-20-69 11:10 P.M.</b>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>48 MARYLAND GEN. HOSP.</b>				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>1510</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b> D. STREET ADDRESS (If rural, give location) <b>3902 W. COLDSRING LAKE</b>			
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>M</b>	8. DATE OF BIRTH <b>2-01-87</b>	9. AGE (In years last birthday) <b>82</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>ERNEST LEES</b>				14. MOTHER'S MAIDEN NAME <b>EICHORN</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>25-07-9563</b>		17. INFORMANT ADDRESS <b>WIFE - JOSEPHINE LEES - SAME</b>			
18. <b>480X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>Acute Respiratory Insufficiency</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>2° Left Ventr. Rebe Pneumonia</b>				(A) DUE TO		INTERVAL BETWEEN ONSET AND DEATH <b>DAYS</b>	
				(B) DUE TO		<b>DAYS</b>	
				(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>Acute Congestive Heart Failure 20ASCD.</b>							
19A. DATE OF OPERATION <b>D</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>12-20 19 69</b> to <b>12-20 19 69</b> , that (I) (we) last saw the deceased alive on <b>12-20 19 69</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (I) (We) (did not) view the body after death.							
23A. SIGNATURE <b>Angelita A. Topand</b>				23B. DATE SIGNED <b>12-20-69</b>			
23C. PHYSICIAN'S NAME (Type) <b>ANGELITA TOPAND M.D.</b>				23D. ADDRESS <b>Maryland Gen. Hospital</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>12-24-69</b>		24C. NAME OF CEMETERY or CREMATORY <b>MORELAND MEM PK</b>		24D. LOCATION (City, town, or county) (State) <b>BALTO. MD.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 29 1969</b>		25B. NAME OF REGISTRAR <b>Robert E. Salyer</b>		25C. FUNERAL DIRECTOR <b>Wm. J. TUCKER &amp; SONS</b>		ADDRESS <b>BALTO. MD.</b>	



# FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>69 12837</u>
1. NAME OF DECEASED (Type or Print) <b>MCKAY, WILLIAM HENRY</b>		2. DATE AND HOUR OF DEATH <b>DECEMBER 27, 1969 3:34 A. M.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <b>ST AGNES HOSPITAL CATON &amp; WILKENS AVENUES BALTIMORE, MARYLAND 21229</b>		A. STATE <b>MARYLAND</b> B. COUNTY <b>ANNE ARUNDEL</b> C. CITY OR TOWN <b>MT PLEASANT BEACH</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
5. SEX <b>MALE</b> 6. RACE <b>WHITE</b> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>11/23/94</b> 9. AGE (In years last birthday) <b>75</b>		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY <b>Balto City</b>		11. BIRTHPLACE (State or foreign country) <b>Md</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>William H McKay Sr</b>		
14. MOTHER'S MAIDEN NAME <b>Margaret Ingram</b>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		
16. SOCIAL SECURITY NO. <b>217-09-5571</b>		17. INFORMANT <b>ST AGNES' RECORDS CATON &amp; WILKENS AVES</b>		
18. <b>157.9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Carcinoma of pancreas - generalized metastatic</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>(A) IMMEDIATE CAUSE</b> <b>(B) DUE TO, OR AS A CONSEQUENCE OF:</b> <b>(C) DUE TO, OR AS A CONSEQUENCE OF:</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that <b>XIX</b> (this hospital) attended the deceased from <b>NOVEMBER 28</b> 19 <b>69</b> to <b>DECEMBER 27</b> 19 <b>69</b> that <b>IX</b> (we) last saw the deceased alive on <b>DECEMBER 27</b> 19 <b>69</b> and that in <b>XX</b> (our) opinion death occurred on the date and hour and from the causes stated above <b>XIX</b> (We) (did) (did not) view the body after death.				
23A. SIGNATURE <b>JCSADA</b>		23B. DATE SIGNED <b>12/27/69</b>		23C. PHYSICIAN'S NAME (Type) <b>MOANGSON</b>
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12/30/69</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Glen Haven Mem Pk</b>
24D. LOCATION (City, town, or county) <b>Glen Burnie</b>		24E. ADDRESS <b>ST AGNES HOSPITAL CATON &amp; WILKENS AVES</b>		24F. STATE <b>AA Co Md</b>
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 29 1969</b>		25B. NAME OF REGISTRAR <b>John E. Kelly, M.D.</b>		25C. FUNERAL DIRECTOR <b>McBride F.H. 737</b>
25D. ADDRESS <b>21229</b>				





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

F-655 69 12838				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 69 12838	
1. NAME OF DECEASED (Type or Print) <i>Cora S. Freeman</i>				2. DATE AND HOUR OF DEATH <i>DEC. 23, 69 8<sup>25</sup> P.M.</i>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>90 House in the Pines Nursing Home (Belair)</i>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>26-31</i> C. CITY OR TOWN <i>Baltimore</i> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <i>5837 Belair Road</i>			
5. SEX <i>F</i>	6. RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>1/22/'78</i>	9. AGE (In years last birthday) <i>97</i>	If Under 1 Yr. Months: Days: Hours: Min.	If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Worked in Dinery</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Henry H. XXXXX XXXX Gerding</i>			14. MOTHER'S MAIDEN NAME <i>Margaret E. Hopkins</i>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give work or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>217-24-6786</i>		17. INFORMANT <i>Mr. Leroy Gerding</i>			
				ADDRESS <i>220 S. Highland Ave</i>			
18. <i>433.9 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) IMMEDIATE CAUSE <i>CEREBRAL THROMBOSIS</i> DUE TO, OR AS A CONSEQUENCE OF:  (B) <i>ARTERIOSCLEROSIS</i> DUE TO, OR AS A CONSEQUENCE OF:  (C) _____			
				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <i>D</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>OCT 11 1960</i> to <i>DEC 23 1969</i> , that (I) (we) last saw the deceased alive on <i>DEC 23 1969</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>Robert E. May M.D.</i>				23B. DATE SIGNED <i>12/24/69</i>			
23C. PHYSICIAN'S NAME (Type) <i>ROBERT E. MAY M.D.</i>		23D. ADDRESS <i>5662 THE ALAMEDA BALTO. MD.</i>					
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>12/27/'69</i>		24C. NAME OF CEMETERY or CREMATORY <i>Oak Lawn Cemetery</i>		24D. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>DEC 29 1969</i>		25B. NAME OF REGISTRAR <i>Robert E. May, M.D.</i>		25C. FUNERAL DIRECTOR <i>John A. Moran, Inc.</i>			
				ADDRESS <i>3000 E. Baltimore St.</i>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.	69 12839
M-250		69 12839		CERTIFICATE OF DEATH	
BIRTH NO.					
1. NAME OF DECEASED (Type or Print) <i>George H. McKlvane (McWayne)</i>			2. DATE AND HOUR OF DEATH <i>8PM 12/25/69</i>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <i>X THE JOHNS HOPKINS HOSPITAL</i>			A. STATE <i>MARYLAND</i>		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			B. COUNTY <i>6-05</i>		
			C. CITY OR TOWN <i>BALTIMORE</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER <i>202 BEALE ST.</i>		
5. SEX <i>M</i>	6. RACE <i>NEGRO</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>4/6/98</i>	9. AGE (In years last birthday) <i>71</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Laborer - Retired</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Retired</i>		11. BIRTHPLACE (State or foreign country) <i>North Carolina</i>	
13. FATHER'S NAME <i>William McKlvane</i>		14. MOTHER'S MAIDEN NAME <i>Atla ?</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>no</i>		16. SOCIAL SECURITY NO. <i>246-12-4145A</i>		17. INFORMANT ADDRESS <i>Mrs. Louise McKlvane 202 Beale Ct. 21202</i>	
18. <i>410.9 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <i>Cardiac Arrest</i> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>M Coronial Infarction</i>			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		
19. DATE OF OPERATION <i>None</i>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>None</i>		
20A. AUTOPSY? (Yes or No) <i>yes</i>			20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from <i>12/21</i> 19 <i>69</i> to <i>12/25</i> 19 <i>69</i> , that (I) (we) last saw the deceased alive on <i>12/25</i> 19 <i>69</i> and that in (my) <i>X</i> opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) <i>X</i> (not) view the body after death.					
23A. SIGNATURE <i>Rein Saral MD</i>			23B. DATE SIGNED <i>12/25</i>		
23C. PHYSICIAN'S NAME (Type) <i>REIN SARAL M.D.</i>			23D. ADDRESS <i>THE JOHNS HOPKINS HOSPITAL</i>		
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>12-30-1969</i>		24C. NAME OF CEMETERY or CREMATORY <i>Mt. Auburn Cemetery</i>	
24D. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>		25A. DATE REC'D BY HEALTH DEPT. <i>DEC 29 1969</i>			
25B. NAME OF REGISTRAR <i>Robert E. Taylor</i>		25C. FUNERAL DIRECTOR <i>Marshall W. Jones, Jr.</i>			

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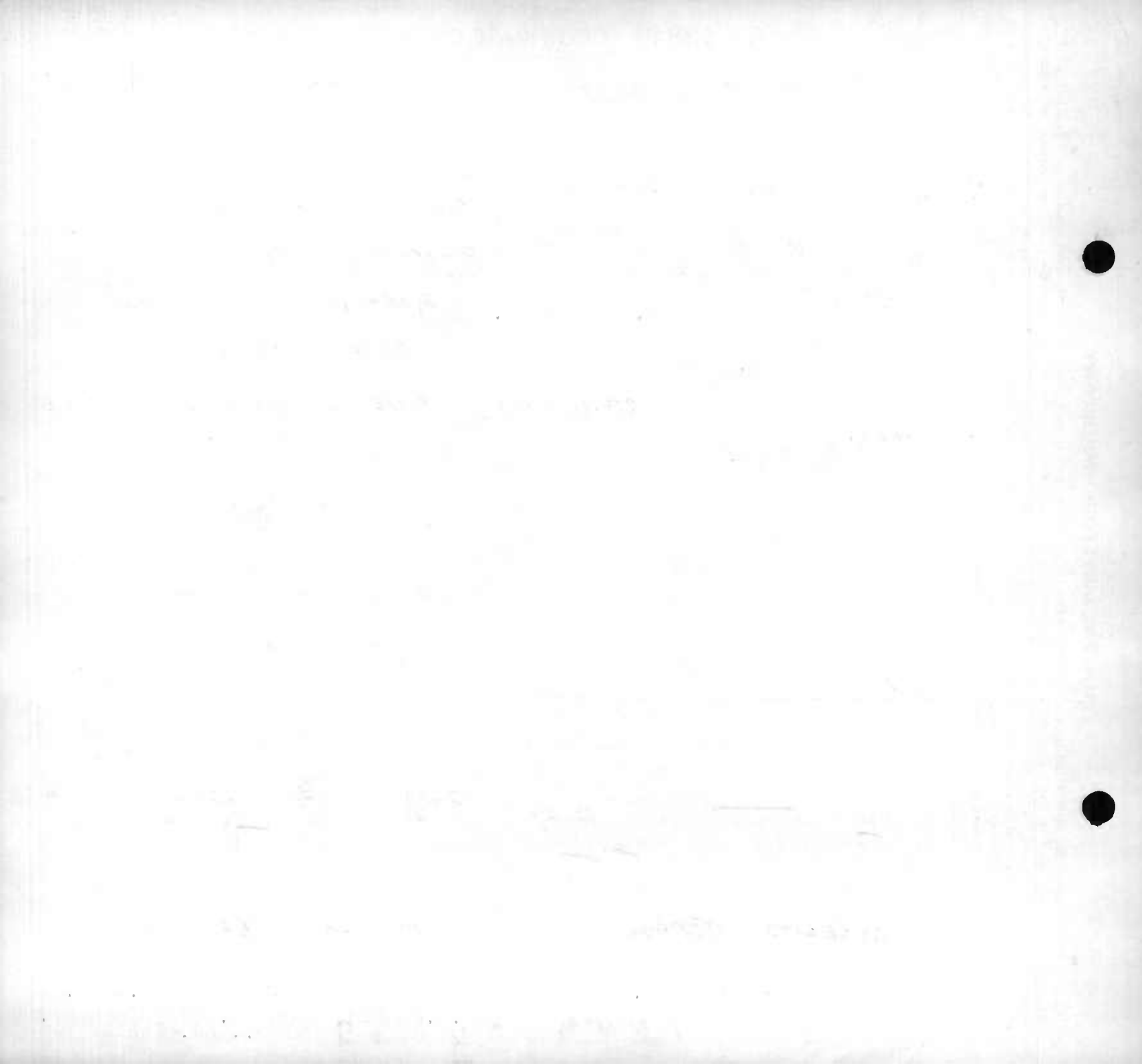
Re. J. J. J.

15/12

**FUNERAL DIRECTOR: IMPORTANT**

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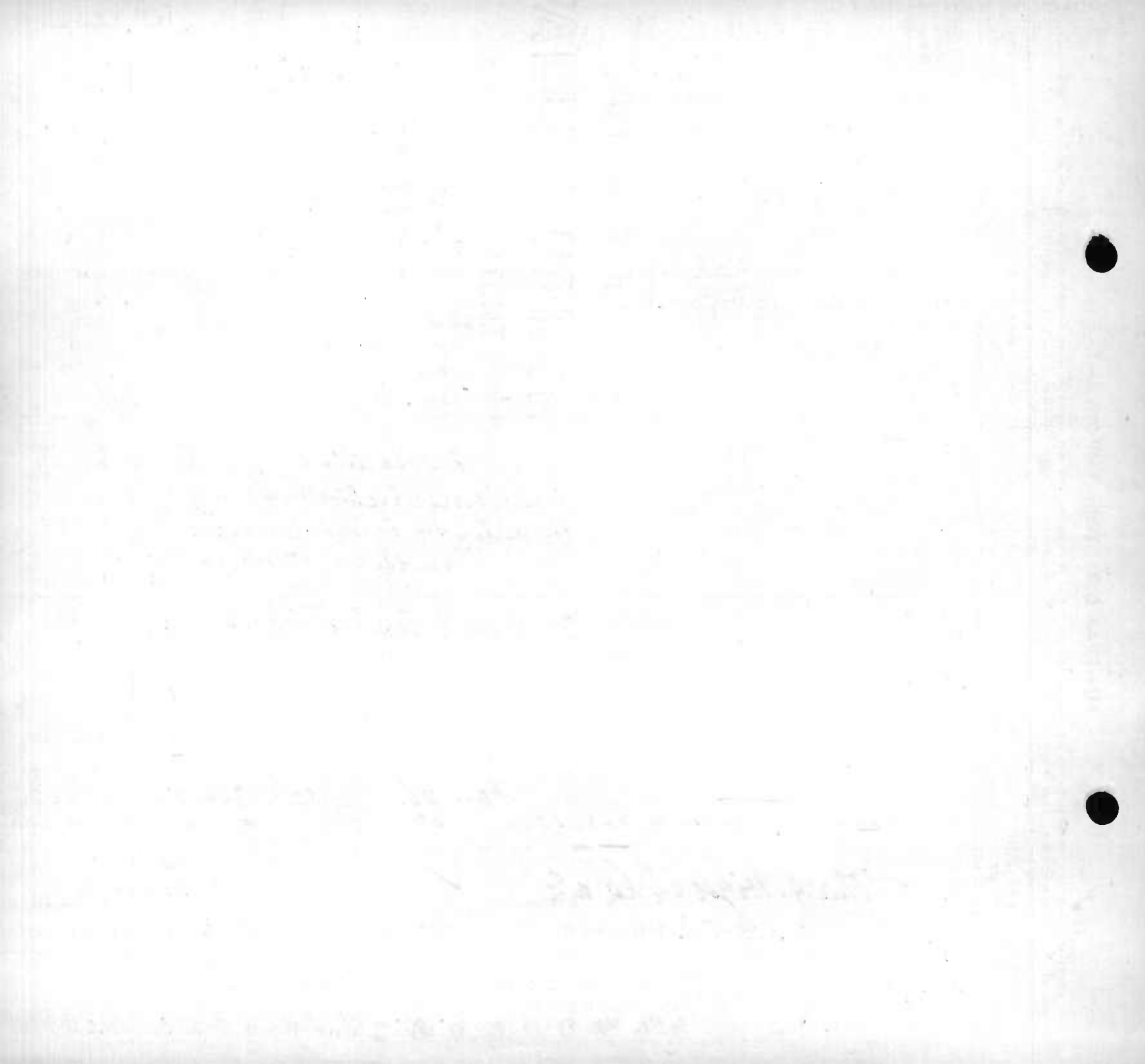
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <b>69 12840</b>	
BIRTH NO. <b>69 12840</b>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>GEORGE E. WOLF</b>		2. DATE AND HOUR OF DEATH <b>12-27-69</b> <b>12:20 P</b> M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>27-78</b>			
FULL NAME OF HDSPITAL OR INSTITUTION <b>MARYLAND GEN. HOSPITAL</b>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b>			
		D. STREET ADDRESS (If rural, give location) <b>5822 HAL WYN AVE</b>			
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Married</b>	8. DATE OF BIRTH <b>3-10-1898</b>	9. AGE (In years last birthday) <b>71</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Balto. Transit Co.</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>GEORGE M. Wolf</b>			14. MOTHER'S MAIDEN NAME <b>MORA FREDERICK</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>213-05-9777A</b>		17. INFORMANT <b>WIFE - IDA WOLF</b> ADDRESS <b>SAME</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>MYOCARDIAL INFARCT</b>		CAUSE OF DEATH (A) DUE TO <b>ARTEROSCLEROTIC HEART DISEASE</b>		INTERVAL BETWEEN ONSET AND DEATH <b>4 DAYS</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO		(C) DUE TO	
<b>II</b>					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>Yes</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>12-27</b> 19 <b>69</b> to <b>12-27</b> 19 <b>69</b> , that (I) (we) last saw the deceased alive on <b>12-27</b> 19 <b>69</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Angelita Topacio</b> M.D.				23B. DATE SIGNED <b>12-27-69</b>	
23C. PHYSICIAN'S NAME (Type) <b>ANGELITA TOPACIO</b>		23D. ADDRESS <b>MARYLAND GEN. HOSPITAL</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12-30-69</b>		24C. NAME OF CEMETERY or CREMATORY <b>St. John's Lutheran</b>	
				24D. LOCATION (City, town, or county) (State) <b>Leister, Carroll Co., Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 29 1969</b>		25B. NAME OF REGISTRAR <b>Paul E. Fisher</b>		25C. FUNERAL DIRECTOR <b>H.W. Jenkins Sons Co.</b> ADDRESS <b>4905 York Rd. Balto., Md. 21212</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.	69 12841
BIRTH NO. 69 12841		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Carl O. Peterson			2. DATE AND HOUR OF DEATH Dec. 27, 1969 8 <sup>35</sup> pm M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  44 Union Memorial Hospital			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 27-48 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 5703 Leith Walk		
5. SEX M	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-7-1902	9. AGE (In years last birthday) 67	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Representative-Brolite Corp. Baking			10B. KIND OF BUSINESS OR INDUSTRY Ingredients		11. BIRTHPLACE (State or foreign country) Iowa
12. CITIZEN OF WHAT COUNTRY? U.S.A			13. FATHER'S NAME Charles Peterson		
14. MOTHER'S MAIDEN NAME Ann Swanson			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		
16. SOCIAL SECURITY NO. 413-03-4912-A			17. INFORMANT Mrs. Goldie Peterson		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, assthenia, etc. It means the disease, injury or complication which caused death.)  DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).  19A. DATE OF OPERATION 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 19C. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) 19D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) 19E. INJURY OCCURRED While At <input type="checkbox"/> Not White At Work <input type="checkbox"/> 19F. HOW DID INJURY OCCUR? 20A. AUTOPSY? (Yes or No) 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Myocardial Infarction Instantly Arteriosclerotic coronary artery disease 17 years. (B) DUE TO, OR AS A CONSEQUENCE OF: Hypertensive Cardio-Cerebral Vascular Disease 18 years. (C) Cerebral Arteriosclerosis 3 1/2 years.		
21A. DATE OF OPERATION			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			21D. TIME OF INJURY (APPROX.)		
21E. INJURY OCCURRED			21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (the hospital) attended the deceased from Jan 26 1952 to Dec 27 1969, that (I) (we) last saw the deceased alive on Dec 19 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.			23A. SIGNATURE John H. Hirschfeld M.D. 23B. DATE SIGNED 12/29/69 23C. PHYSICIAN'S NAME (Type) Dr. John H. Hirschfeld 23D. ADDRESS 6919 Harford Road Baltimore 21234		
24A. BURIAL CREMATION, REMOVAL (Specify) Rem. Burial			24B. DATE 12/31/69		
24C. NAME OF CEMETERY or CREMATORY Glendale Cemetery			24D. LOCATION West Des Moines, Iowa		
25A. DATE REC'D BY HEALTH DEPT. DEC 29 1969			25B. NAME OF REGISTRAR H. W. Jenkins & Sons Co. 25C. FUNERAL DIRECTOR 2905 York Road Balto., Md. 21212		





# FUNERAL DIRECTOR: IMPORTANT

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M-6001

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 69 12842	
BIRTH NO. 69 12842		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) MAIER, J. WILLIAM, D.		2. DATE AND HOUR OF DEATH Dec 27, 1969 7:00 AM			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION SINAI HOSPITAL OF BALTIMORE (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 42		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY 12-01 C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 31 YORK COURT #18			
5. SEX M	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-26-86	9. AGE (In years last birthday) 83	10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TECHNICIAN		10B. KIND OF BUSINESS OR INDUSTRY DENTAL		11. BIRTHPLACE (State or foreign country) BALTIMORE	
13. FATHER'S NAME J. WILLIAM D. MAIER		14. MOTHER'S MAIDEN NAME THERESA STEPHAN			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 214-16-6455		17. INFORMANT ADDRESS PATIENT CHART AS ABOVE	
18. 532.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: PULMONARY EDEMA		(B) DUE TO, OR AS A CONSEQUENCE OF:	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		DUODENAL ULCER & PERFORATION		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION 12-18-69		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED PERFORATED DUODENAL ULCER		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from DEC 18 1969 to DEC 27 1969 that (I) (we) last saw the deceased alive on DEC 27 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE I. San Gabriel JR MD		23B. DATE SIGNED 12/27/69		23C. PHYSICIAN'S NAME (Type) I. SAN GABRIEL JR MD	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12-29-69		24C. NAME OF CEMETERY or CREMATORY Oaklawn	
24D. LOCATION Balto.		24E. LOCATION (City, town, or county) Md.		24F. LOCATION (City, town, or county) Md.	
25A. DATE REC'D BY HEALTH DEPT. DEC 29 1969		25B. NAME OF REGISTRAR Robert E. Taylor MD		25C. FUNERAL DIRECTOR H.W. Jenkins & Sons Co., Balto., Md.	

WILLIAM J. VAIR

25 1980

ST. ALBANS HOSPITAL OF BATHING

21 YRS OLD

X

WHITE

M

2-20-80

ST. ALBANS HOSPITAL

PATIENT

BIRMINGHAM

DOUGLAS GUY

15-18-80

DEC 18 1980

MD

12-18-80

MD

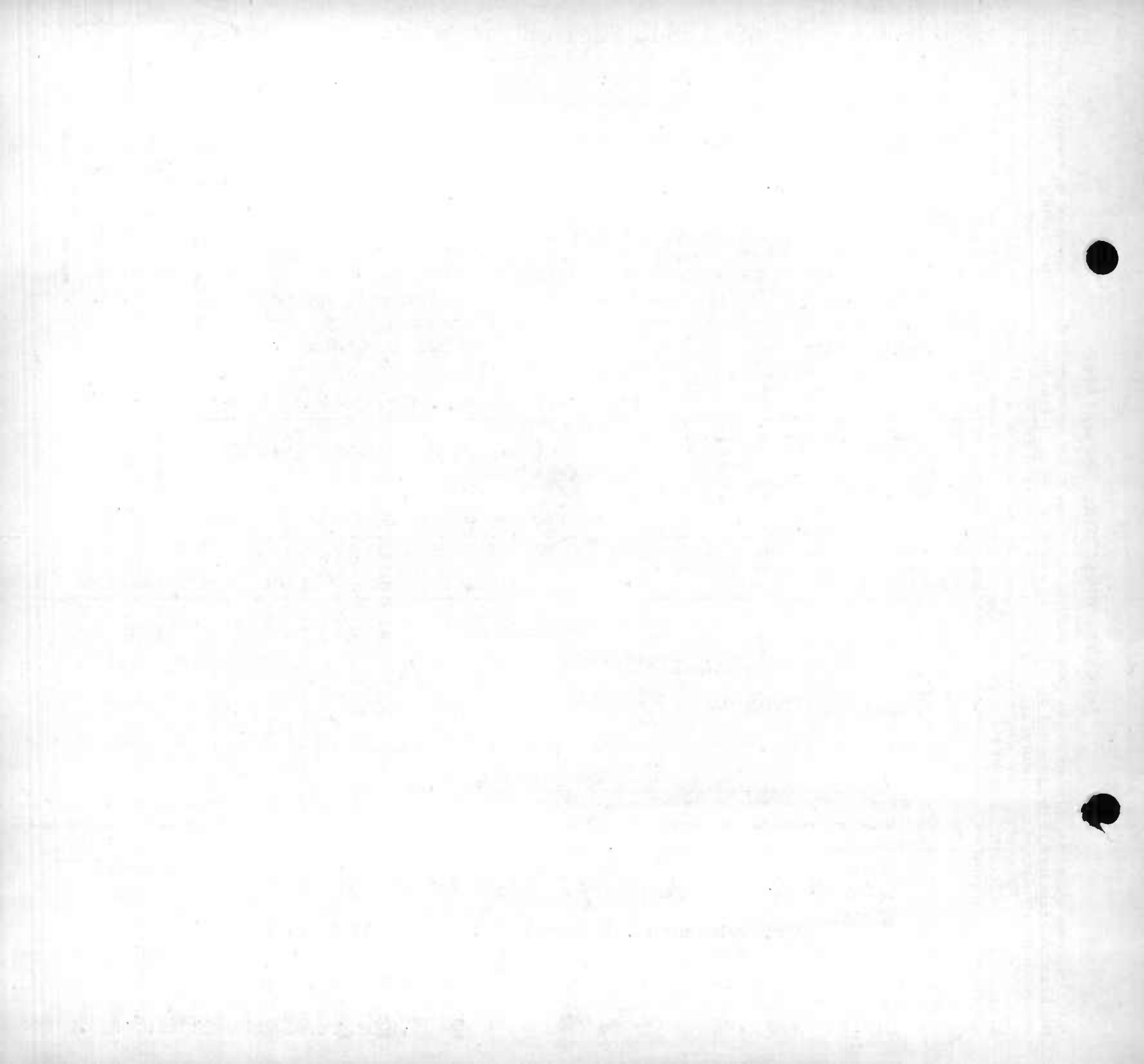
1-20-80

ST. ALBANS HOSPITAL OF BATHING

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.
69 12843		CERTIFICATE OF DEATH		69 12843
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH		
Edna Louise Kistner		Dec. 24- 1969		7:30 P. M.
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE B. COUNTY		
3726 Ellerslie Avenue		Maryland		
		C. CITY OR TOWN		D. INSIDE CITY LIMITS?
		Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
		E. STREET AND NUMBER		
		3726 Ellerslie Ave.		
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)
F	W	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	7-19-1907	62
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)
Housewife		Own Home		Baltimore, Maryland
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?
John Smith		Bessie Childs		U.S.A.
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT
No		215-28-9909		Mr. George H. Kistner
				ADDRESS
				Same
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		Congestive Heart Failure		6 mos.
ANTECEDENT CAUSES		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		Rheumatic Heart Disease		47 yrs.
		(B) DUE TO, OR AS A CONSEQUENCE OF:		
		(C) _____		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		Diabetes Mellitus		11 yrs.
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
				no
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		
22. I certify that (I) (this hospital) attended the deceased from July 1961 to Dec. 1969, that (I) last saw the deceased alive on Dec. 24 1969 and that in (my) (attending) death occurred on the date and hour and from the causes stated above. (I) (did not) view the body after death.				
23A. SIGNATURE		23B. DATE SIGNED		
Wm. H. Kammer, Jr.		27 Dec. 69		
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS		
Dr. William H. Kammer, Jr.		6011 York Road		
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY
Burial		12-29-1969		Moreland Memorial Park
				Baltimore, County, Md.
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR
DEC 29 1969		J. E. Taber, MD.		Henry W. Jenkins & Sons Co.
				ADDRESS
				4205 York Road Balto., Md. 21212



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>69 12844</u>	
BIRTH NO. <u>69-18704</u>		<b>CERTIFICATE OF DEATH</b>			
1. NAME OF DECEASED (Type or Print) <u>Baptist, Karen</u>			2. DATE AND HOUR OF DEATH <u>12-19-69</u> <u>1:30</u> P.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>42 Sinai Hospital of Balt.</u>			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>15-12</u>		
			C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER <u>3704 Reisterstown Road</u>		
5. SEX <u>F</u>	6. RACE <u>N</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10-10-69</u>	9. AGE (In years last birthday) <u>2 mos</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Baltimore</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>ERIC BAPTIST</u>			14. MOTHER'S MAIDEN NAME <u>VIRGINIA LANE</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>                    </u>		17. INFORMANT <u>Eric Baptist</u> ADDRESS <u>3704 Reisterstown</u>	
18. <u>422X1</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.			CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>Myocarditis</u> DUE TO, OR AS A CONSEQUENCE OF:  <u>Viremia</u> (B) _____ DUE TO, OR AS A CONSEQUENCE OF: (C) _____		
			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Approx 12 hrs</u>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>Yes</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>11:30 AM 12-19-69</u> to <u>1:30 PM 12-19-69</u> , that (I) (we) last saw the deceased alive on <u>12-19-69</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Sara Smith</u>			23B. DATE SIGNED <u>12-19-69</u>		
23C. PHYSICIAN'S NAME (Type) <u>SA</u>			23D. ADDRESS <u>Sinai Hospital</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>12-24-69</u>		24C. NAME of CEMETERY or CREMATORY <u>National Cemetery</u>	
24D. LOCATION (City, town, or county) (State) <u>5500 Frederick Rd Baltimore Md</u>					
25A. DATE REC'D BY HEALTH DEPT. <u>DEC 29 1969</u>		25B. NAME OF REGISTRAR <u>Robert E. Fisher, Jr.</u>		25C. FUNERAL DIRECTOR <u>1922 Edmonson Ave</u>	

ERIC BAPTIST

5/11/1955

204

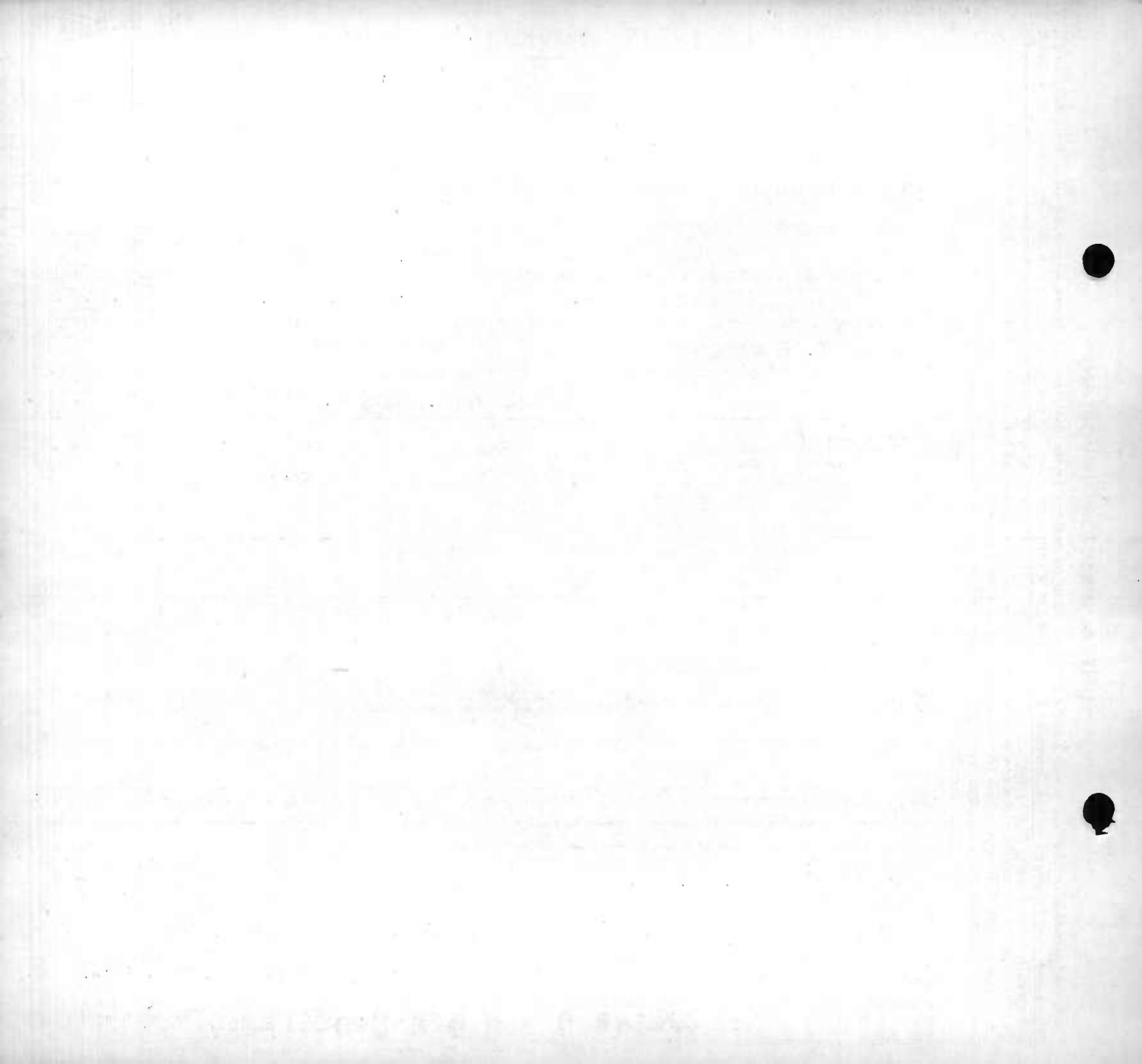
# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

## BALTIMORE CITY HEALTH DEPARTMENT 69 12845 CERTIFICATE OF DEATH

REG. NO. **69 12845**

BIRTH NO. <b>69 12845</b>		2. DATE AND HOUR OF DEATH <b>Dec. 26, 1969 7:30 A. M.</b>	
1. NAME OF DECEASED (Type or Print) <b>Maude Grace Smith</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>12-02</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>Edith Parks Nursing Home</b> <b>1449 Medfield Avenue</b> <b>90</b>		C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <b>F</b> 6. RACE <b>W</b> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>3-4-1879</b> 9. AGE (In years last birthday) <b>90</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Homemaker</b>		11. BIRTHPLACE (State or foreign country) <b>Carroll Co., Md.</b>	
10B. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Alfred T. Buckingham</b>		14. MOTHER'S MAIDEN NAME <b>Emma Shauck</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>220-44-2822</b>	
17. INFORMANT <b>Mrs. Betty J. Rice</b>		ADDRESS <b>1093 1020 Jamieson Rd.</b>	
18. <b>412.41</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Arteriosclerotic cardiovascular disease</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Arteriosclerotic cardiovascular disease</b> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) <b>sev. years</b>	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) <b>No</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>Jan 19 1968</b> to <b>Dec 26 1969</b> , that (I) (we) last saw the deceased alive on <b>Dec 11 1969</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.			
23A. SIGNATURE <b>Alfred G. Ossman Jr. M.D.</b>		23B. DATE SIGNED <b>12-26-69</b>	
23C. PHYSICIAN'S NAME (Type) <b>Alfred G. Ossman Jr. M.D.</b>		23D. ADDRESS <b>1101 St Paul St Balto 2 Md.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12-29-1969</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Druid Ridge Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Pikesville, Balto. Co., Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 29 1969</b>		25B. NAME OF REGISTRAR <b>Robert E. Jenkins</b>	
25C. FUNERAL DIRECTOR <b>Henry W. Jenkins &amp; Sons Co.</b>		ADDRESS <b>4006 York Road Balto., Md. 21212</b>	





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 69 12846				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 69 12846	
1. NAME OF DECEASED (Type or Print) Cecil I. Usher				2. DATE AND HOUR OF DEATH 12/21/69 M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 38 University Hospital				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 301 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 36 N. Eden St.			
5. SEX Male	6. RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6-4-03	9. AGE (In years last birthday) 66	10. Under 1 Yr. Months Days	11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working-life, even if retired) Merchant Seaman				11. BIRTHPLACE (State or foreign country) Charleston, N.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME unk.				14. MOTHER'S MAIDEN NAME unk.			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO.				16. SOCIAL SECURITY NO. 202-08-2019		17. INFORMANT Mrs. Dorothy Frazer 1321 E. Fayette St	
18. 412.4 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cardio-Respiratory Failure massive Cerebral Vascular Hemorrhage (B) DUE TO, OR AS A CONSEQUENCE OF: Ant Cerebral Syndrome (C) Chronic Renal Syndrome				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Nov 24 1969 to Dec 21 1969, that (I) (we) last saw the deceased alive on Dec 21 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death.							
23A. SIGNATURE William D. Applefield						23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) William D. Applefield						23D. ADDRESS 6615 Nursteistm A	
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/29/69		24C. NAME OF CEMETERY or CREMATORY John A. Baker Cem.		24D. LOCATION (City, town, or county) (State) Baltimore Maryland	
25A. DATE REC'D BY HEALTH DEPT. DEC 29 1969		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR Hochman Dyck F.H.		ADDRESS 1701 Laurens	

Charles Thompson  
University of California  
Berkeley  
Box 944  
Berkeley, California

Box 51  
June 21

Box 944  
Berkeley, California

William Lloyd Garrison  
Boston, Mass.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>69 12847</u>
BIRTH NO. <u>69 12847</u>		<b>CERTIFICATE OF DEATH</b>		
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>Bren Marr Warwick</u>		2. DATE AND HOUR OF DEATH <u>12-26-69</u>
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>15-13</u>		
FULL NAME OF HOSPITAL OR INSTITUTION <u>00 4224 Towanda Ave</u>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u>		
		D. STREET ADDRESS (If rural, give location) <u>4224 Towanda Ave</u>		
5. SEX <u>Female</u>	6. RACE <u>Negro</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Single</u>	8. DATE OF BIRTH <u>10-5-1956</u>	9. AGE (In years lost birthday) <u>13</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>School</u>	11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Rufus T. Warwick</u>			14. MOTHER'S MAIDEN NAME <u>Sarah Warwick</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No.</u>		16. SOCIAL SECURITY NO. <u>-0-</u>	17. INFORMANT <u>Mr. Rufus Warwick</u>	
				ADDRESS <u>4224 Towanda Ave</u>
18. <u>425X1</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <u>HEART FAILURE</u>		CAUSE OF DEATH (A) DUE TO <u>CARDIOMYOPATHY - OF</u> (B) DUE TO <u>UNKNOWN ETIOLOGY</u> (C) _____		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from _____ 19____ to _____ 19____, that (I) (we) last saw the deceased alive on _____ 19____ and that in (my) (our) opinion death occurred on the date _____ and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <u>B. A. C.</u>		M.D. Attending Phys. <input checked="" type="checkbox"/> Mod. Director <input type="checkbox"/> Stiff Phys. <input type="checkbox"/>		23B. DATE SIGNED
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS M.D.		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	24B. DATE <u>12/29/69</u>	24C. NAME OF CEMETERY OR CREMATORY <u>Mt. Calvary Cem.</u>		24D. LOCATION (City, town, or county) (State) <u>A.A. Co. Maryland</u>
25A. DATE REC'D BY HEALTH DEPT. <u>DEC 29 1969</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, Jr.</u>		25C. FUNERAL DIRECTOR ADDRESS <u>1701 Loureans St.</u>



69 12848 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

69 12848

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

MINNIE POOLE

2. DATE  
OF  
DEATHKnown ☐ Estimated ☐

Month

Day

Year

Hour

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL  
OR INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)3. DATE  
PRONOUNCED DEAD

Month

Day

Year

Hour

December 24, 1969

3:40 P.M.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

6. SEX

Female

7. RACE

Negro

8. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒NO ☐

9. DATE OF BIRTH

1-1-1919

10. AGE (In years  
last birthday)

50

# Under 1 Yr. # Under 24 Hrs.  
Months Days Hours Min.

E. STREET AND NUMBER

630 W. Franklin Street

11. BIRTHPLACE (State or foreign country)

Amelia Co., Virginia

12. CITIZEN OF  
WHAT COUNTRY?  
U.S.A.

13. FATHER'S NAME

Iceman Lawrence

14A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Cook

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Unk.

16. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or doies of service)

No

17. SOCIAL  
SECURITY NO.

229-18-4366

18. INFORMANT

ADDRESS

Mr. Madison Poole

1919 McCulloh Street

19. 412.41

CAUSE OF DEATH

Arteriosclerotic cardiovascular disease

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, ashenia, etc. It means the disease,  
injury or complication which caused death.)

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART 1 (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

Yes

22A. EXTERNAL CAUSE WAS  
UNDERLYING ☐ OR CONTRIB-  
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (if in Baltimore City, give exact location)  
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY  
(APPROX.)

22E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATUREEXAMINER'S  
NAME (Type)

Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

December 25, 1969

24A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

12-29-69

24C. NAME OF CEMETERY or CREMATORY

Balto. National Cem.

24D. LOCATION (City, town, or county)

Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

MORTON &amp; DYETT F.H. 1701 Laurens St.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 69 12849	
BIRTH NO. 69 12849				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) CLARA SMITH.			2. DATE AND HOUR OF DEATH 5:30 AM. 12/22/69.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE MARYLAND B. COUNTY 1603		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) LUTHERAN HOSP. BALTIMORE 720 ASHBURTON ST.			C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
5. SEX F. 6. RACE NEGRO 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH 2-2-97		9. AGE (In years lost birthday) 72
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Greenville, N.C.	
13. FATHER'S NAME Charlie Gray			14. MOTHER'S MAIDEN NAME Nancy Gray		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO.			16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Ethel Green 3505 Woodland Ave
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, as heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cardiovascular shock, And Anemia - due to (B) DUE TO, OR AS A CONSEQUENCE OF: (C) severe bodily burns Dehydration		
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 27 hrs.					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 0 -		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED -		20A. AUTOPSY? (Yes or No) -	
21A. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) home		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Burns, neck, lower chest was Lt Entirely buttocks thighs	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) 12 21 69		21E. INJURY OCCURRED White <input type="checkbox"/> At Work Not White <input checked="" type="checkbox"/> At Work		21F. HOW DID INJURY OCCUR? Involved in fire. 1603	
22. I certify that (I) (this hospital) attended the deceased from 12/21/1969 to 12/22/1969, that (I) (we) last saw the deceased alive on 12/22/1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Subash C. Ahuja, M.D.				23B. DATE SIGNED 12/22/69	
23C. PHYSICIAN'S NAME (Type) SUBASH C. AHUJA, M.D.				23D. ADDRESS Lutheran Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 12/28/69		24C. NAME OF CEMETERY or CREMATORY ARBUS MEMORIAL PK	
24D. LOCATION BALTIMORE MD 21217		24E. DATE REC'D BY HEALTH DEPT.		24F. NAME OF REGISTRAR	
24G. FUNERAL DIRECTOR N 948 09 6 9 0 0		24H. ADDRESS 1201 Laurens St.		24I. DATE OF DEATH 12/22/69	





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 69 12850		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 69 12850	
1. NAME OF DECEASED (Type or Print) Handy, John W.		2. DATE AND HOUR OF DEATH DEC, 23, 1969 DEC, 23, 1969 6:50 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE Maryland B. COUNTY 2733		C. CITY OR TOWN 4901 Pilgrim Rd. D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION George Washington Nursing Home		E. STREET AND NUMBER Baltimore			
5. SEX Male	6. RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 17, 1875	9. AGE (In years) 94 yrs	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) School teacher		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Greenbrier, Md.	
13. FATHER'S NAME Benjamin Handy		14. MOTHER'S MAIDEN NAME Sarah Margaret		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No.		16. SOCIAL SECURITY NO.		17. INFORMANT Mr. Benjamin Handy 4901 Pilgrim	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) DISEASE OR CONDITION DIRECTLY LEADING TO DEATH 412.4 I ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: CONGESTIVE HEART FAILURE (B) DUE TO, OR AS A CONSEQUENCE OF: GENERALIZED ARTERIOSCLEROSIS (C) PNEUMONIA; LEFT AR AMPUTATION APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH MONTH YEARS					
19A. DATE OF OPERATION 11-12-69		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED VASCULAR DISEASE		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from JUNE 19 69 to 23 DEC 19 69, that (1) (we) last saw the deceased alive on 22 DEC 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Richard F. Tyson, MD		23B. DATE SIGNED 12-23-69		23C. PHYSICIAN'S NAME (Type) Richard F. Tyson, MD	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/28/69		24C. NAME of CEMETERY or CREMATORY Mt. Calvary United Ch. Cem	
24D. LOCATION (City, town, or county) (State) Greenbrier, Maryland		25A. DATE REC'D BY HEALTH DEPT. DEC 29 1969		25B. NAME OF REGISTRAR Robert E. Taylor, MD	
25C. FUNERAL DIRECTOR ADDRESS		25D. NAME OF FUNERAL HOME F.H. 1701 Laurens St.			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

## BALTIMORE CITY HEALTH DEPARTMENT 69 12851 CERTIFICATE OF DEATH

REG. NO.

69 12851

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>RANDALL, MARGARET</b>		2. DATE AND HOUR OF DEATH <b>12-26-69 12:50 P.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>1512</b>		C. CITY OR TOWN <b>BALTIMORE</b>	
FULL NAME OF HOSPITAL OR INSTITUTION <b>1251 NAI HOSPITAL</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		E. STREET AND NUMBER <b>2814 Norfolk Ave #15</b>	
5. SEX <b>Female</b>	6. RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8-25-1910</b>	9. AGE (in years last birthday) <b>59</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		11. BIRTHPLACE (State or foreign country) <b>Norfolk, Virginia</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>JAMES L. BOOTH</b>		14. MOTHER'S MAIDEN NAME <b>Pauline C. Coates</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No.</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mrs. Margorie Jones 2814 Norfolk Ave</b>	
18. <b>205.01</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>ACUTE GRANULOCYTIC LEUKEMIA.</b>		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF:			
(C) _____					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>SEIZURES - ? 2ary to above</b>					
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>YES</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>NO</b>	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (A) (this hospital) attended the deceased from <b>12-19-69</b> 19 to <b>12-26-69</b> 19 that (B) (we) last saw the deceased alive on <b>12-26-69</b> 19 and that (C) (our) opinion death occurred on the date and hour and from the causes stated above. (D) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>M. Bodenkheimer M.D.</b>				23B. DATE SIGNED <b>12-26-69</b>	
23C. PHYSICIAN'S NAME (Type) <b>M. BODENHEIMER M.D.</b>		23D. ADDRESS <b>Sinai Hospital</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12/30/69</b>		24C. NAME OF CEMETERY or CREMATORY <b>Arbutus Mem. Park</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>		25A. DATE RECEIVED BY HEALTH DEPT. <b>DEC 29 1969</b>			
25B. NAME OF REGISTRAR <b>E. E. Jones</b>		25C. FUNERAL DIRECTOR <b>Harold Dyer F.H. 1701 Laureus St.</b>			



69 12852

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

69 12852

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) <b>EDWARD H. SMITH</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> 12 23 69 8:23 p.m.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>Johns Hopkins Hospital D.O.A.</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>Dec. 23, 1969 8:23 p.m.</b>	
6. SEX <b>Male</b>		7. RACE <b>Negro</b>	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>1205</b>	
9. DATE OF BIRTH <b>8-19-1912</b>		10. AGE (In years last birthday) <b>57</b>	
11. BIRTHPLACE (State or foreign country) <b>Harford Co., Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Robert Smith</b>		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>	
15. MOTHER'S MAIDEN NAME <b>Blanche Smith</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes 3/12/41 11/9/45</b>	
17. SOCIAL SECURITY NO. <b>217-14-1014</b>		18. INFORMANT ADDRESS <b>Mr. Al Jenkins Rte 2 Box 103 Farmingdale N.J.</b>	
19. CAUSE OF DEATH <b>E965X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION <b>2</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) <b>YES</b>			
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Home</b>	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? <b>1808 Guilford Ave. 1205</b>		22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) <b>12 23 69 8:08p</b>	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? <b>Subject shot</b>	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <b>Ronald N. Kornblum</b> M.D. EXAMINER'S NAME (Type) <b>Ronald N. Kornblum M.D.</b> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>12/24/69</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12-30-69</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Baltimore Nat'l Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 29 1969</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor, M.D.</b>	
25C. FUNERAL DIRECTOR <b>MORTON &amp; DYETT F.H.</b>		ADDRESS <b>1701 Laurens St.</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				X		REG. NO. 69 12853	
BIRTH NO. 69 12853		CERTIFICATE OF DEATH					
1. NAME OF DECEASED (Type or Print) IDA WYNN MACKLIN		2. DATE AND HOUR OF DEATH DEC. 25, 1969, 10 <sup>40</sup> A.M.					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY BALTO. CO. 5300					
FULL NAME OF HOSPITAL OR INSTITUTION 38 UNIV. OF MD. HOSP		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 219 CHESTNUT ST.			
5. SEX F	6. RACE N	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9/27/92	9. AGE (In years last birthday) 77	10. If Under 1 Yr. Months: Days: Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) VIRGINIA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME WILLIAM WYNN				14. MOTHER'S MAIDEN NAME NANCY ALLEN			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO.		17. INFORMANT HOSP. CHART		ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) E880X PROBABLE PULM. EMBOLUS		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2-3 HRS.			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: ISCHIAL FRACTURE		(B) DUE TO, OR AS A CONSEQUENCE OF: 2 DAYS			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A) REFRACTORY ANEMIA							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input checked="" type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) HOME		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 219 CHESTNUT ST., BALTO 21212			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) DEC. 24, 69 1AM		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? MISSED STEP AND FELL DOWN STAIRS			
22. I certify that (this hospital) attended the deceased from DEC 24 19 69 to DEC 25 19 69 that (we) last saw the deceased alive on DEC 25 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
23A. SIGNATURE Marvin J. Gordon, M.D.				23B. DATE SIGNED 12/25/69			
23C. PHYSICIAN'S NAME (Type) MARVIN J. GORDON, M.D.		23D. ADDRESS DEPT. OF MEDICINE UNIV. OF MD. HOSP.					
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 12/28/69		24C. NAME OF CEMETERY OR CREMATORY Miles Chapel Cemetery		24D. LOCATION (City, town, or county) (State) LaCrosse, Virginia	
25A. DATE REC'D BY HEALTH DEPT. DEC 29 1969		25B. NAME OF REGISTRAR R. E. Jaber, M.D.		25C. FUNERAL DIRECTOR MORTON & DYETT		ADDRESS FUNERAL HOMES, INC.	

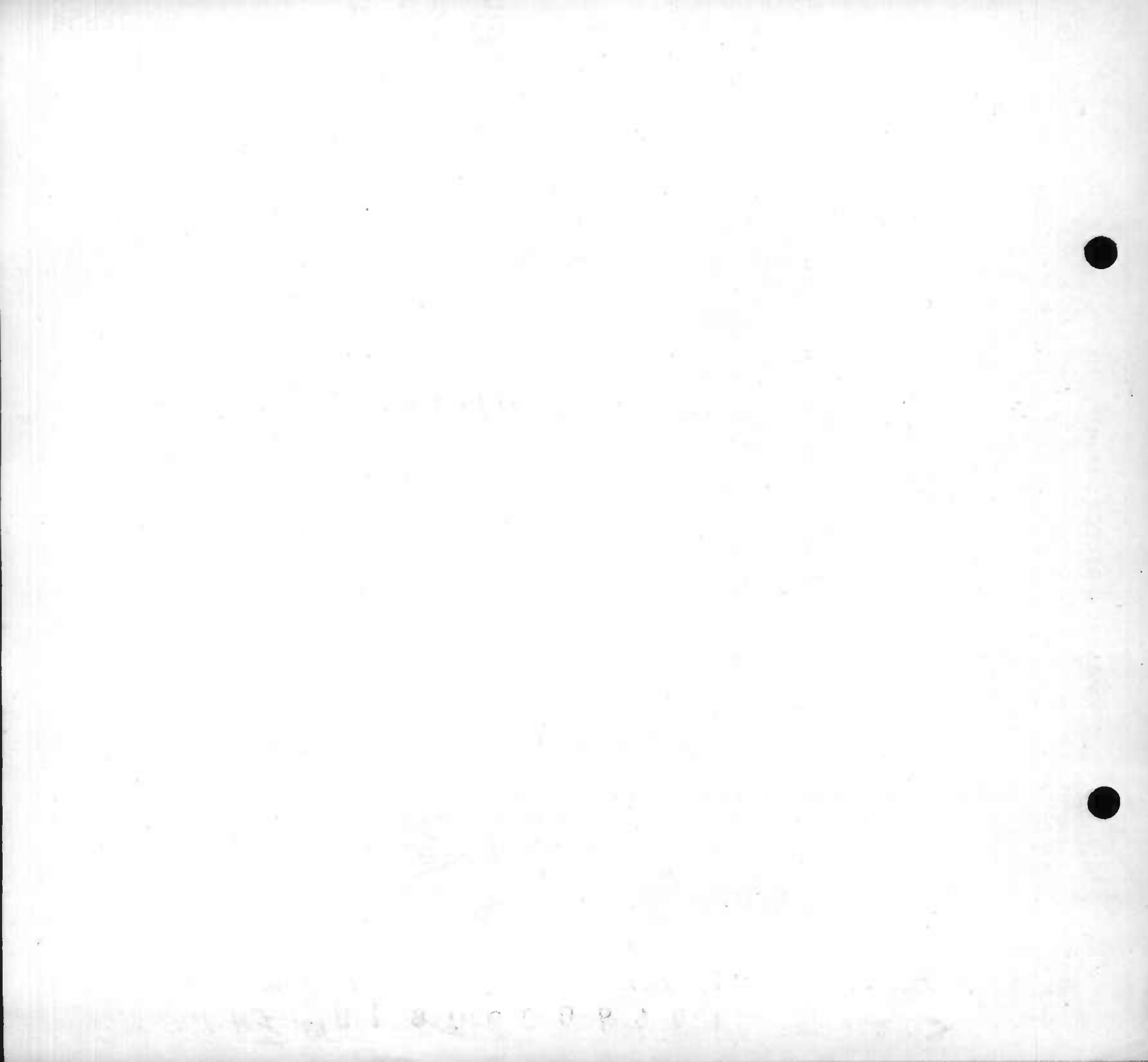




FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

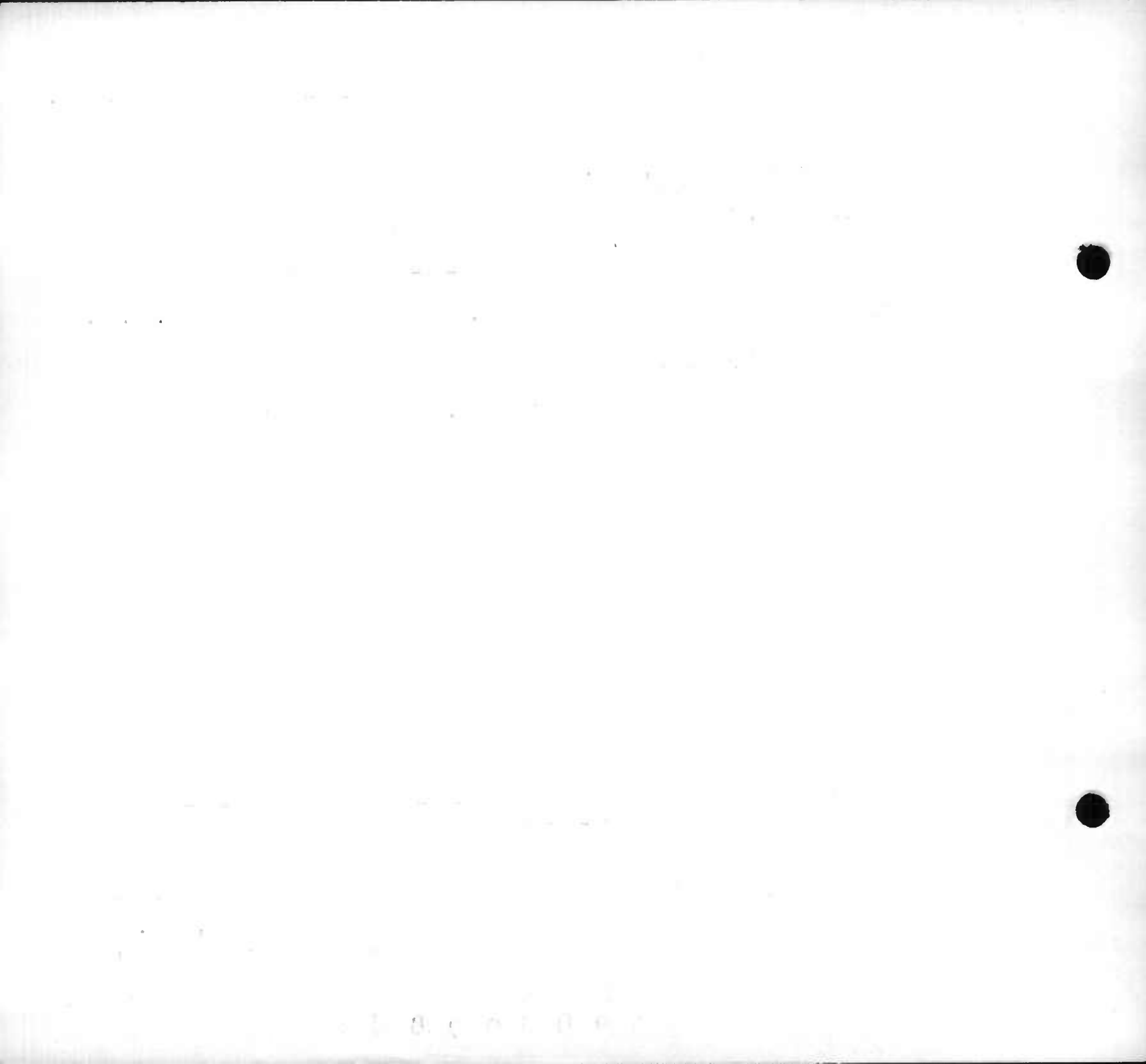
69 12854		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 69 12854	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>Helen M. Blackwell</b>		2. DATE AND HOUR OF DEATH <b>12-26-69 10:10 AM. M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>1547</b>		C. CITY OR TOWN <b>Baltimore</b>	
FULL NAME OF HOSPITAL OR INSTITUTION <b>LUTHERAN Hospital</b>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <b>3306 Clifton Avenue</b>		5. SEX <b>Female</b>		6. RACE <b>NEGRO</b>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>5-24-08</b>		9. AGE (In years last birthday) <b>61</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Goochland, Virginia</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>unk</b>		14. MOTHER'S MAIDEN NAME <b>unk.</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO.</b>		16. SOCIAL SECURITY NO. <b>212-22-6448</b>		17. INFORMANT <b>Mr. Robert Blackwell</b>	
18. <b>157.9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Cardiorespiratory Failure</b>		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Carcinoma Pancreas.</b>		(B) DUE TO, OR AS A CONSEQUENCE OF:	
(C) DUE TO, OR AS A CONSEQUENCE OF:		II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (X) (this hospital) attended the deceased from <b>10-13-1969</b> to <b>12-26-1969</b> , that (I) (we) last saw the deceased alive on <b>12-26-1969</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <b>Zaheer Ahmad Khan</b>		23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type) <b>ZAHEER AHMAD KHAN</b>	
23D. ADDRESS <b>% LUTHERAN Hosp. of MD.</b>		24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12/29/69</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Arbutus Mem. Park</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>		25A. DATE REC'D BY HEALTH DEPT. <b>DEC 29 1969</b>	
25B. NAME OF REGISTRAR <b>Robert E. Talley, MD.</b>		25C. FUNERAL DIRECTOR <b>Moreland</b>		ADDRESS <b>Byett F.H. 1701 Laurens St.</b>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <b>69 12855</b>	
BIRTH NO. <b>69 12855</b>				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <b>Alexander Clayton</b>			2. DATE AND HOUR OF DEATH <b>12-27-69 8:15 a. m.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland</b> B. CITY OR TOWN <b>Baltimore</b> C. STREET AND NUMBER <b>2204 Pennsylvania Avenue</b>		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>Provident Hospital, Inc. 1514 Division Street Baltimore, Maryland 21217</b>			D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
5. SEX <b>Male</b>	6. RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1-11-03</b>	9. AGE (In years last birthday) <b>66</b>	10. Under 1 Yr. Months Days Hours Min. If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Unemployed</b>			11. BIRTHPLACE (State or foreign country) <b>St. Mary Cpmnty (Maryland)</b>		
13. FATHER'S NAME <b>William Clayton</b>			12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No.</b>			14. MOTHER'S MAIDEN NAME <b>Maggie Hawkins</b>		
16. SOCIAL SECURITY NO. <b>214-14-3701A</b>			17. INFORMANT <b>Mrs. Eva Thomas (Friend)</b>		
18. <b>436.0 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>Cerebrovascular Accident</b> DUE TO, OR AS A CONSEQUENCE OF: (A) IMMEDIATE CAUSE (B) <b>Hypertension</b> DUE TO, OR AS A CONSEQUENCE OF: (C) _____ ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Ischemic Cardiovascular Disease</b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>12 hours</b>		
MEDICAL CERTIFICATION					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>Ischemic Cardiovascular Disease</b>					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>12-26-69</b> 19__ to <b>12-27-69</b> 19__ that (I) (we) last saw the deceased alive on <b>12-27-69</b> 19__ and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>M. J. Shari</b>			23B. DATE SIGNED <b>12-27-69</b>		
23C. PHYSICIAN'S NAME (Type) <b>M. JAVARD SHARI</b>			23D. ADDRESS <b>Provident Hospital, Inc. 1514 Division Street - Baltimore, Maryland</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12-31-69</b>		24C. NAME OF CEMETERY OR CREMATORY <b>New Cathedral Cem.</b>	
24D. LOCATION <b>Baltimore, Maryland</b>		25A. DATE REC'D BY HEALTH DEPT. <b>DEC 29 1969</b>			
25B. NAME OF REGISTRAR <b>Robert E. Fisher, M.D.</b>		25C. FUNERAL DIRECTOR <b>MORTON &amp; DYETT F.H. 1701 Laurens St.</b>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

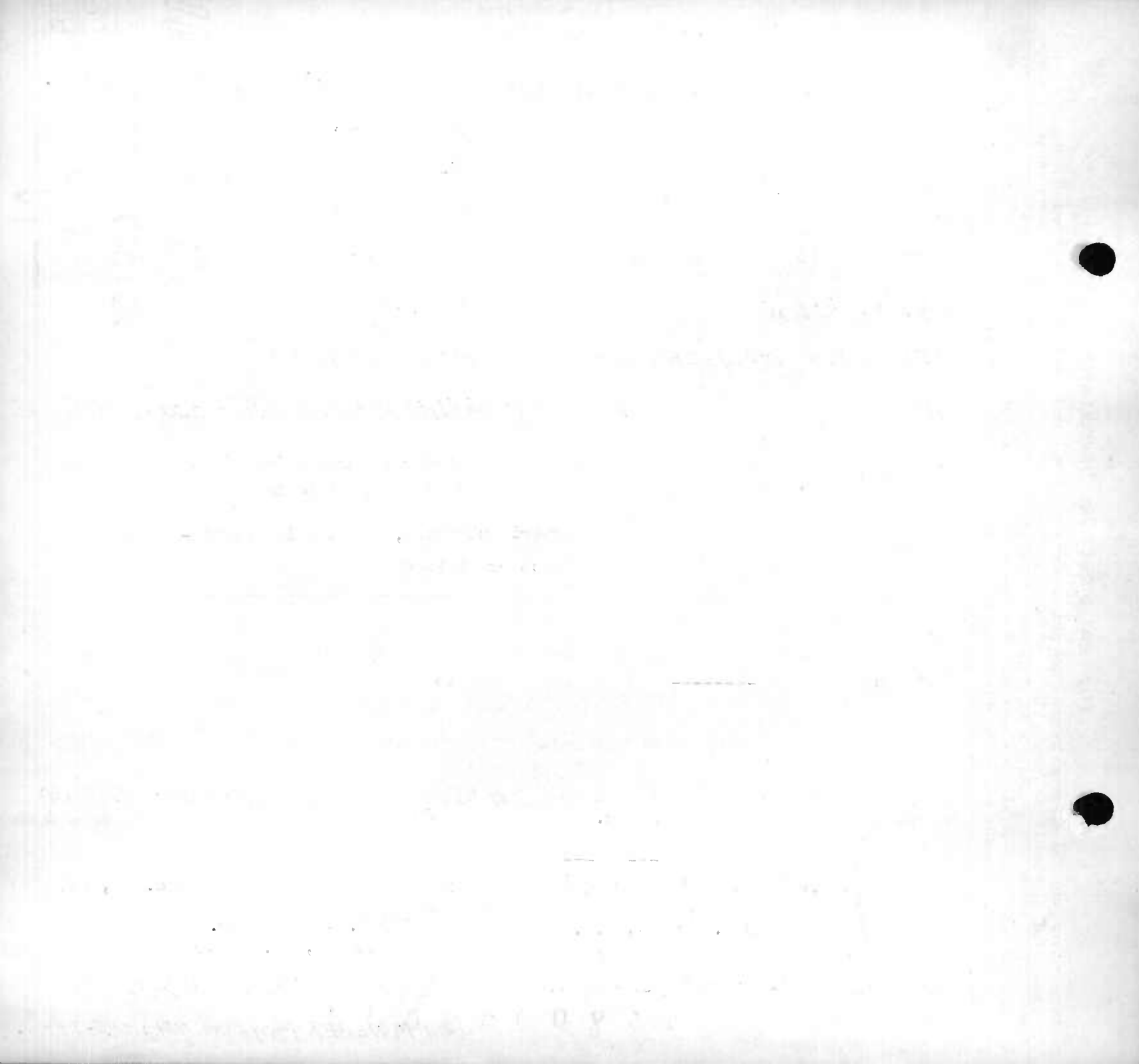
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="float: right;">69 12856</span>	
BIRTH NO. <span style="float: right;">69 12856</span>		<div style="display: flex; justify-content: space-between;"> <div>1. NAME OF DECEASED (Type or Print) <b>BOGACKI EMILIA</b></div> <div>2. DATE AND HOUR OF DEATH <b>12/24/1969 10:45 AM</b></div> </div>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <b>CH4 HOME HOSPITAL 35</b>		A. STATE <b>MARYLAND</b>		B. COUNTY <b>201</b>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <b>BALTIMORE</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER <b>406 S. WASHINGTON ST.</b>			
5. SEX <b>F</b>	6. RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7/30/197</b>	9. AGE (In years last birthday) <b>92+</b>	If Under 1 Tr. Months Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House wife</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>POLAND</b>	
13. FATHER'S NAME <b>FRANCIS BOGACKI</b>		14. MOTHER'S MAIDEN NAME <b>MARIK'VI UNKNOWN</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>213-30-8008</b>		17. INFORMANT <b>JOHN BOGACKI 406 S. WASHINGTON ST.</b>	
18. <b>250.9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>Cardiac arrest</b>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <b>Diabetes mellitus systemic Hypertension - possible MI</b> DUE TO, OR AS A CONSEQUENCE OF:			
(C) _____					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>12/24</b> 19 <b>69</b> to <b>12/24/69</b> 19 <b>69</b> that (I) (we) lost saw the deceased alive on <b>12/24/69</b> 19 <b>69</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>FILORZI</b>		23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type) <b>FILORZI</b>	
23D. ADDRESS		23E. DEGREE <b>MD</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>12/29/69</b>		24C. NAME of CEMETERY or CREMATORY <b>ST. STANISLAUS CEM.</b>	
24D. LOCATION <b>DUNDALK MD.</b>		24E. DATE REC'D BY HEALTH DEPT. <b>DEC 29 1969</b>			
24F. NAME OF REGISTRAR <b>Robert E. J. [illegible]</b>		24G. NAME OF REGISTRAR <b>0 0 0</b>		24H. FUNERAL DIRECTOR <b>JOHN M. WEAVER &amp; SONS</b>	
24I. ADDRESS <b>406 CHESTER ST.</b>					



**FUNERAL DIRECTOR: IMPORTANT**

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BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <b>69 12857</b>
<b>W-432</b> <b>69 12857</b> <b>CERTIFICATE OF DEATH</b>		<b>2</b> <b>1</b>		
1. NAME OF DECEASED (Type or Print) <b>EMILIA J. WLODKOWSKA</b>		2. DATE AND HOUR OF DEATH <b>12-25-1969</b> <b>6:30 A.</b> M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>201</b>		
FULL NAME OF HOSPITAL OR INSTITUTION <b>218 S. CHESTER ST.</b>		C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
5. SEX <b>F</b> 6. RACE <b>W</b>		E. STREET AND NUMBER <b>218 S. CHESTER ST.</b>		
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>NOV. 5 1888</b> 9. AGE (In years last birthday) <b>81</b>		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>PACKING HOUSE</b>		11. BIRTHPLACE (State or foreign country) <b>POLAND</b> 12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>STANISLAUS MALISZEWSKI</b>		14. MOTHER'S MAIDEN NAME <b>ALEKSANDRA</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>217-073239</b> 17. INFORMANT <b>BERTHA BIALOZYNSKA</b> ADDRESS <b>218 S. CHESTER ST.</b>		
18. <b>412.1 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Cerebral Thrombosis: Right Hemiplegia</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Arteriosclerotic, Hypertensive Cardio-Vascular Disease</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>11/10/64</b> <b>5/23/59</b>		
<b>II</b>				
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION <b>None</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>-----</b>		20A. AUTOPSY? (Yes or No) <b>No</b>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <b>May 23</b> 19 <b>59</b> to <b>December 25</b> 19 <b>69</b> , that (I) (we) last saw the deceased alive on <b>Dec. 25</b> 19 <b>69</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <b>Joseph F. Drenga, M.D.</b>		Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <b>Dec. 29, 1969</b>
23C. PHYSICIAN'S NAME (Type) <b>Joseph F. Drenga, M.D.</b>		23D. ADDRESS <b>209 S. Chester Str. Baltimore, Md. 21231</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>12-30-69</b>		24C. NAME OF CEMETERY OR CREMATORY <b>HOLY ROSARY CEMETERY DUNDALK MARYLAND</b>
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 29 1969</b>		25B. NAME OF REGISTRAR <b>John M. Weber</b>		25C. FUNERAL DIRECTOR ADDRESS <b>JOHN M. WEBER &amp; SONS INC. 401 S. CHESTER ST.</b>

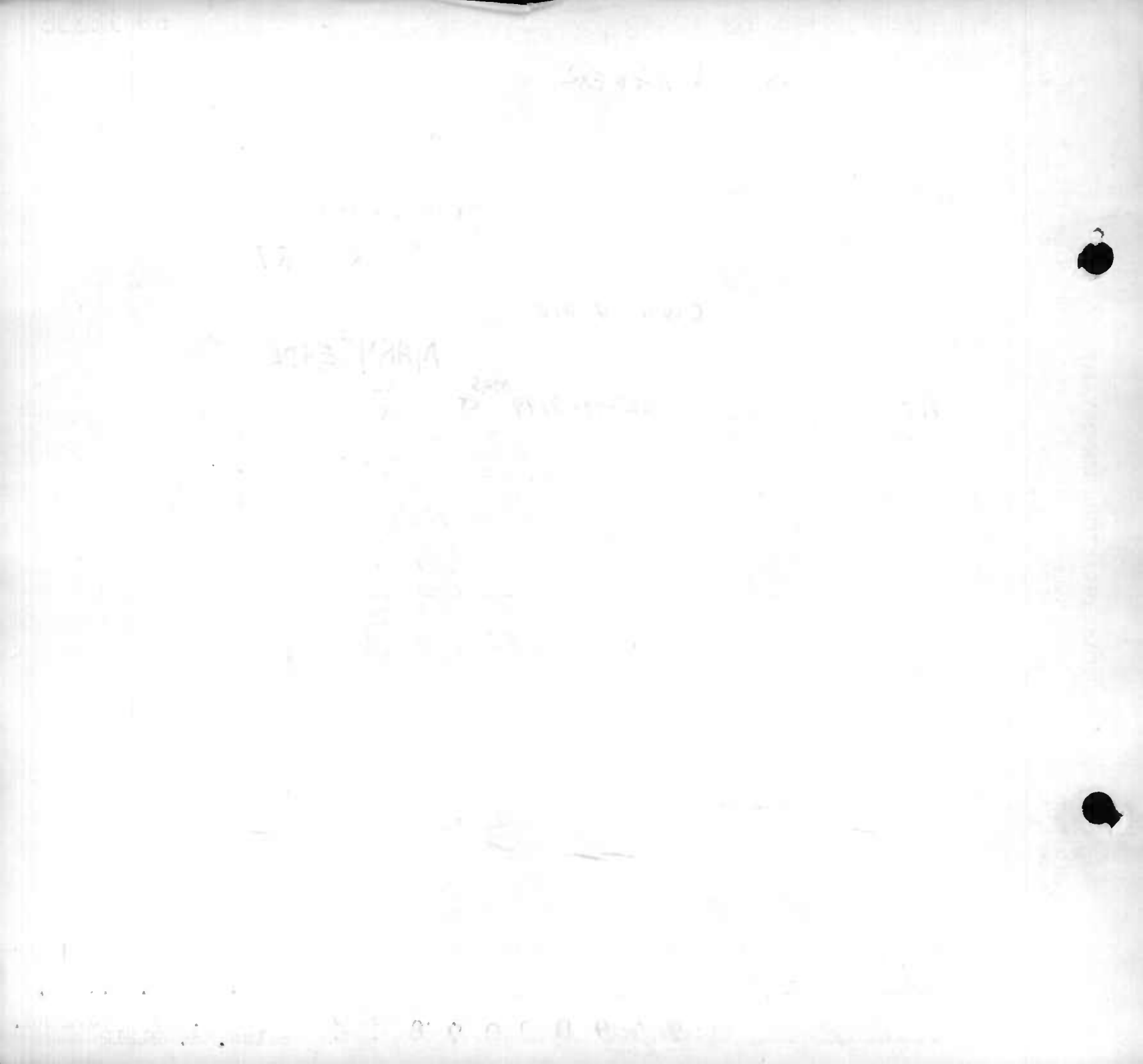




# FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPT.				Registered No. 69 12858	
W-256		69 12858		<b>CERTIFICATE OF DEATH</b>	
BIRTH NO.		M.E. CASE NO.			
1. NAME OF DECEASED (Type or Print) <u>VIVIAN S. WAGNER</u>		2. DATE AND HOUR OF DEATH <u>12/24/69 1 6 30 a.m.</u>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>Maryland GEN. Hospital</u>		A. STATE <u>MD</u> B. COUNTY <u>2711</u>			
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>4804 Norwood Rd. Balt</u>			
		D. STREET ADDRESS (If rural, give location) <u>BALTIMORE Md</u>			
5. SEX <u>FEMALE</u>	6. RACE <u>WHITE</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>WIDOWED</u>	8. DATE OF BIRTH <u>8-2-82</u>	9. AGE (In years last birthday) <u>87</u>	10. Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>		11. BIRTHPLACE (State or foreign country) <u>PENNSYLVANIA</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>GEORGE SIMS</u>			
14. MOTHER'S MAIDEN NAME <u>MARY LEADE</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>			
16. SOCIAL SECURITY NO. <u>220-44-9199</u>		17. INFORMANT <u>MRS. GRACE W. KENNEDY</u>			
18. ADDRESS <u>1323 Benwick Rd. Balto. Md. 21204</u>					
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <u>4 10.9 I</u>		CAUSE OF DEATH <u>Cerebrovascular accident?</u>			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) DUE TO <u>Myocardial Infarction ~ 7 days</u>			
ANTECEDENT CAUSES		(B) DUE TO <u>Asoc Kidney disease</u>			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) <u>Serum</u>			
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>YES</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>12/20</u> 19 <u>69</u> to <u>12/24</u> 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>12/24</u> 19 <u>69</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Enrique, A.</u>				23B. DATE SIGNED <u>12/24/69</u>	
23C. PHYSICIAN'S NAME (Type) <u>Enrique, A.</u>				23D. ADDRESS <u>MARYLAND GENERAL Hosp. BALTO, Md. 21201</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>12/26/69</u>		24C. NAME of CEMETERY or CREMATORY <u>Druid Ridge</u>	
24D. LOCATION (City, town, or county) (State) <u>Pikesville, Balto. Co., Md.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>DEC 29 1969</u>			
25B. NAME OF REGISTRAR <u>Robt. E. Taylor</u>		25C. FUNERAL DIRECTOR <u>H. W. Jenkins &amp; Sons Co. 4905 York Rd. Balto. Md. 21212</u>			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

69 12859

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO.

69 12859

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

HOSIE LEE TODD

2. DATE AND HOUR OF DEATH

DEC. 26, 1969

A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

00 927 N. Carey St.

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE

B. COUNTY

Md.

C. CITY OR TOWN

Balto.

D. INSIDE CITY LIMITS?

YES ☒NO ☐

E. STREET AND NUMBER

927 N. Carey St.

5. SEX

Male

6. RACE

Col.

7. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

8. DATE OF BIRTH

June 13, 1928

9. AGE (In years)

41

If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Laborer

10B. KIND OF BUSINESS OR INDUSTRY

Construction

11. BIRTHPLACE (State or foreign country)

Ala.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Sydney Todd

14. MOTHER'S MAIDEN NAME

Eula Mae Joyner

15. Was Deceased Ever in U. S. Armed Forces?

(Yes, no or unknown) (If yes, give war or dates of service)

Yes

Korean War

16. SOCIAL SECURITY NO.

419-36-1619

17. INFORMANT

ADDRESS

Dorothy Todd 817 W. Saratoga St.

18. 571.9 I

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

CIRRHOSIS OF LIVER

UNKNOWN

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

CHR.

PYELONEPHRITIS

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)

21E. INJURY OCCURRED

While At Work ☐Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from

that (I) (we) last saw the deceased alive on

and hour and from the causes stated above (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Attending Phys. ☒Med. Director ☐Staff Phys. ☐

23B. DATE SIGNED

12/27/69

23C. PHYSICIAN'S NAME (Type)

JOHN S. BRADON JR.

23D. ADDRESS

3600 PARK HTS. AVE, BALTO, MD

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

12/30/69

24C. NAME OF CEMETERY OR CREMATORY

Mt. Calvary Cem.

24D. LOCATION

Cedar Hill Mt.

25A. DATE REC'D BY HEALTH DEPT.

DEC 29 1969

25B. NAME OF REGISTRAR

Robert E. Fisher, Jr.

25C. FUNERAL DIRECTOR

Williams Funeral Home 319 N. Broadway



69 12860

BALTIMORE CITY HEALTH DEPARTMENT

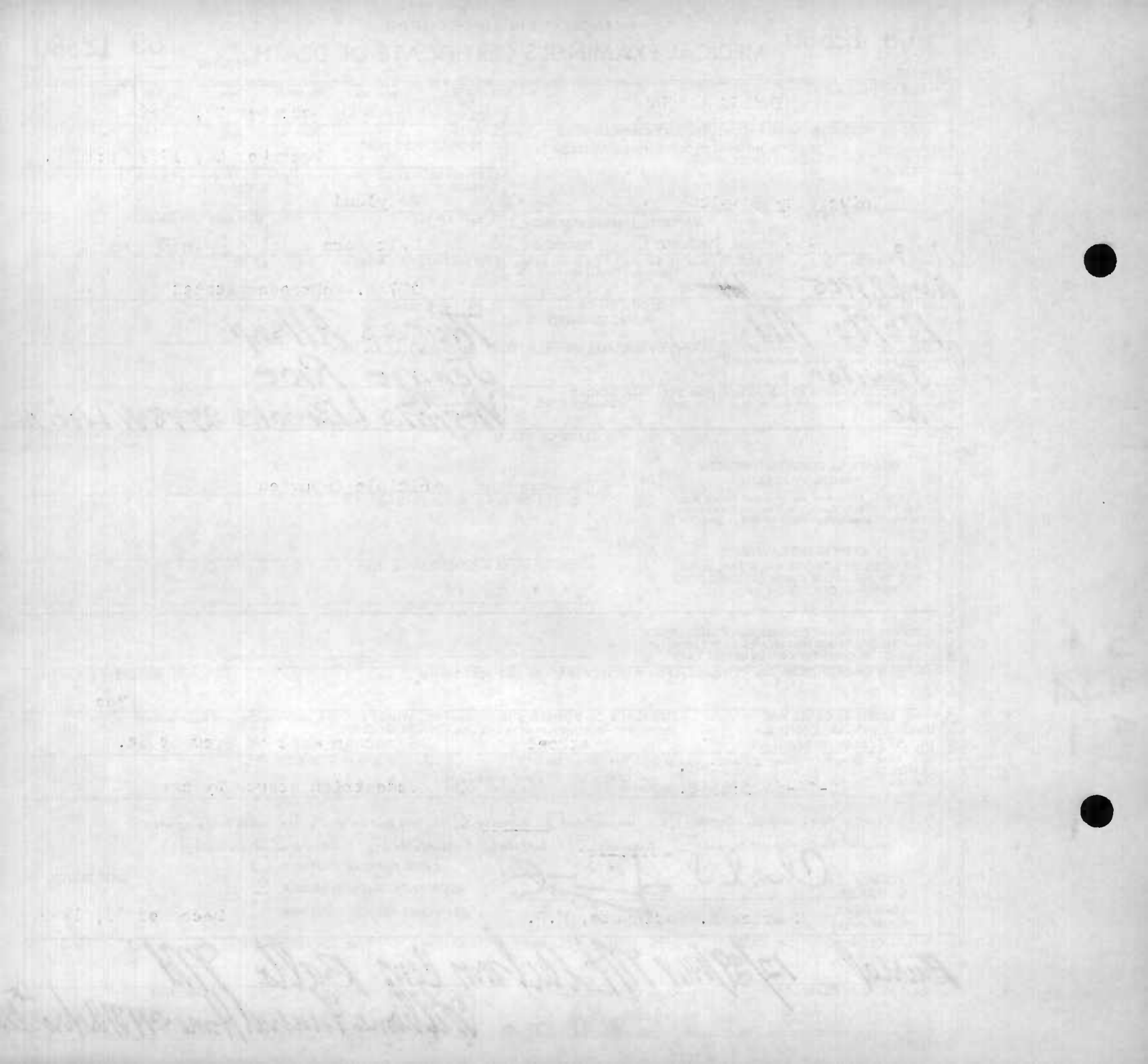
# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

69 12860

BIRTH NC.

REG. NO.

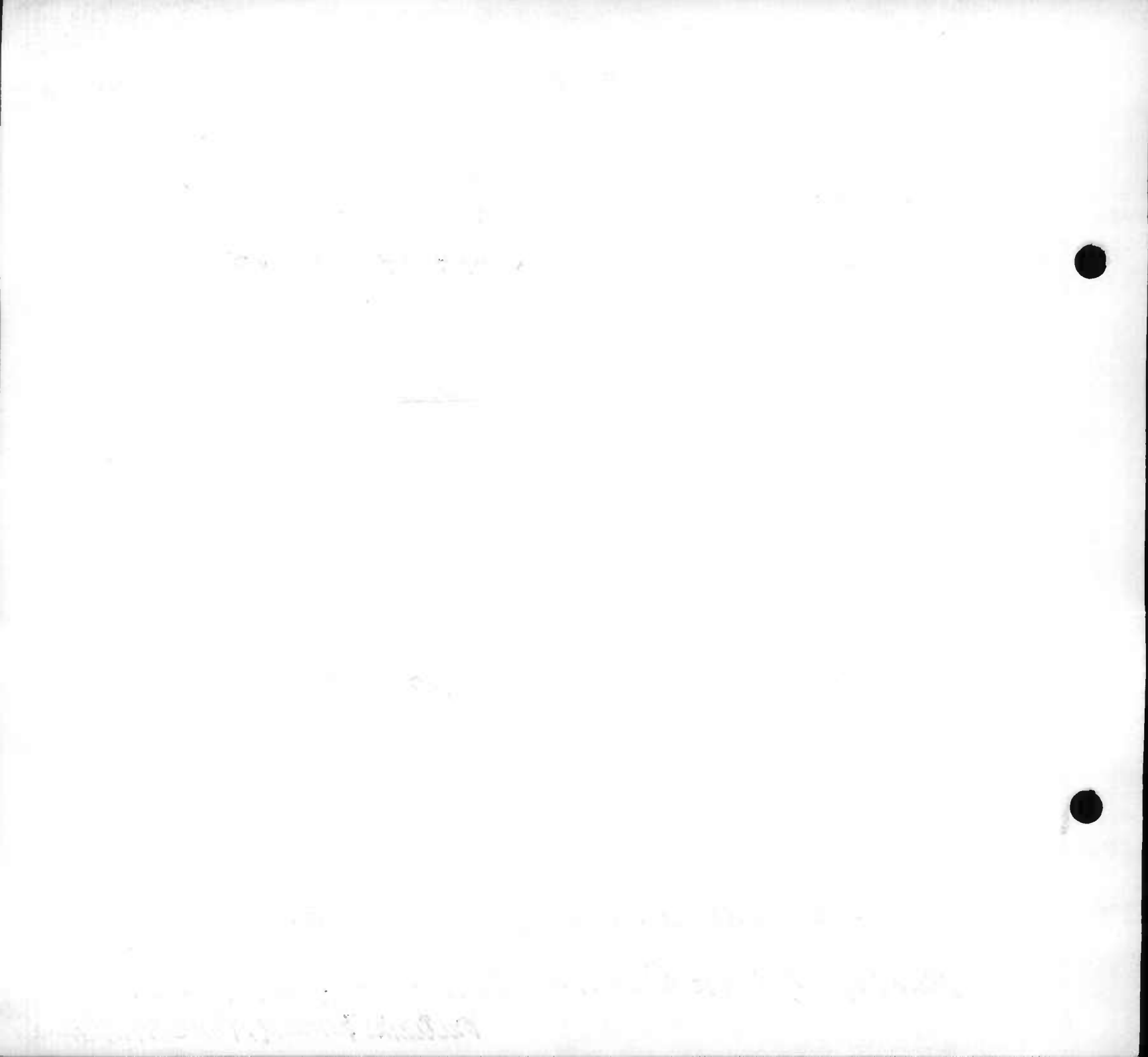
1. NAME OF DECEASED (Type or Print)		IRVING ALLSUP		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year December 24, 1969		Hour M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		3. DATE PRONOUNCED DEAD Month Day Year December 24, 1969		Hour 6:10 P. M.			
FULL NAME OF HOSPITAL OR INSTITUTION University Hospital (DOA)		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 1801					
6. SEX Male		7. RACE Negro		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
9. DATE OF BIRTH March 9, 1905		10. AGE (In years last birthday) 64		11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Thomas Allsup		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Janitor		15. MOTHER'S MAIDEN NAME Jennie Rice		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No	
17. SOCIAL SECURITY NO.		18. INFORMANT Virginia L. Brooks		ADDRESS 2748 W. Loft Ave.			
19. E814.7		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE Multiple injuries DUE TO, OR AS A CONSEQUENCE OF:					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) DUE TO, OR AS A CONSEQUENCE OF:					
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) Yes			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) street		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? Saratoga East of Fremont St.		402	
22D. TIME (Month) (Day) (Approx.) 12-24-69 5:45 P. m.		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? Pedestrian struck by car			
23.		I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Charles S. Springate, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED December 25, 1969			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/29/1969		24C. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cem.		24D. LOCATION (City, town, or county) (State) Baltimore Md.	
25A. DATE REC'D BY HEALTH DEPT. DEC 29 1969		25B. NAME OF REGISTRAR R. E. Taylor		25C. FUNERAL DIRECTOR Williams Funeral Home		ADDRESS 347 N. Schroeder	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				69 12861		CERTIFICATE OF DEATH		REG. NO. 69 12861		
BIRTH NO.				1. NAME OF DECEASED (Type or Print) <b>BATES, IRENE.</b>		2. DATE AND HOUR OF DEATH <b>DEC 27, 69</b>		<b>6-45 A.M.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MD.</b> B. COUNTY <b>402</b>		C. CITY OR TOWN <b>BALTIMORE</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
FULL NAME OF HOSPITAL OR INSTITUTION <b>University of Maryland Hospital</b>				(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		E. STREET AND NUMBER <b>115 N. PEARL ST. 21201</b>				
5. SEX <b>Female</b>	6. RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>5/4/04</b>	9. AGE (In years last birthday) <b>65</b>	10. Under 1 Yr. Months	11. Under 24 Hrs. Days	12. Under 24 Hrs. Hours	13. Under 24 Hrs. Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>NOT KNOWN</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>NOT KNOWN</b>		11. BIRTHPLACE (State or foreign country) <b>NOT KNOWN</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>			
13. FATHER'S NAME <b>NOT KNOWN PETER BATES.</b>				14. MOTHER'S MAIDEN NAME <b>NOT KNOWN Clara BATES.</b>						
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Unknown</b>			16. SOCIAL SECURITY NO. <b>NOT GIVEN</b>		17. INFORMANT <b>Thomas Johnson</b>				ADDRESS <b>115 N. PEARL ST. 21201</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <b>437.71 + 250.9</b> (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Cerebro vascular accident</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>16 hours</b>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO, OR AS A CONSEQUENCE OF: <b>Cerebro vascular Disease</b>						
				(C) DUE TO, OR AS A CONSEQUENCE OF: <b>Atherosclerosis</b>						
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				Probably underlying <b>Diabetes Mellitus</b>						
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)						
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?						
22. I certify that (I) (this hospital) attended the deceased from <b>DEC 26 1969</b> to <b>DEC 27 1969</b> that (I) (we) last saw the deceased alive on <b>DEC 27 1969</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.										
23A. SIGNATURE <b>Haider</b>				M.D. DEGREE Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>				23B. DATE SIGNED <b>Dec. 27, 69.</b>		
23C. PHYSICIAN'S NAME (Type) <b>ZULFIQAR HAIDER</b>				23D. ADDRESS <b>University of Maryland Hospital</b>						
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <b>1/2/70</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Oakwood Cem.</b>		24D. LOCATION (City, town, or county) (State) <b>Richmond Va.</b>				
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 29 1969</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor, M.D.</b>		25C. FUNERAL DIRECTOR <b>Williams Funeral Home</b>		ADDRESS <b>397 School St.</b>				





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

S-343		69 12862		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO.		69 12862	
CERTIFICATE OF DEATH									
1. NAME OF DECEASED (Type or Print) <b>STELTZ, MYRTLE</b>						2. DATE AND HOUR OF DEATH <b>DEC. 25 1969 7 45 P.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>The Union Memorial Hospital</b>						4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>901</b>			
						C. CITY OR TOWN <b>BALTIMORE</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
						E. STREET AND NUMBER <b>621 DUHARTON AVENUE</b>			
5. SEX <b>F</b>	6. RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>2/18/1895</b>	9. AGE (in years last birthday) <b>74</b>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>AMERICAN</b>	
13. FATHER'S NAME <b>Guster Shelton</b>				14. MOTHER'S MAIDEN NAME <b>unknown?</b>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>				16. SOCIAL SECURITY NO. <b>217-18-8084</b>		17. INFORMANT <b>ERNEST COIBERT NASHVILLE - TENN.</b>			
18. <b>433.91</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>BRAIN STEM INFARCTION</b> CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 weeks</b>									
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b>									
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).									
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <b>12/4</b> 19 <b>69</b> to <b>12/24</b> 19 <b>69</b> that (I) (we) last saw the deceased alive on <b>12/24</b> 19 <b>69</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <b>TRISUD TAGAWA</b>						23B. DATE SIGNED <b>12/29/1969</b>			
23C. PHYSICIAN'S NAME (Type) <b>TRISUD TAGAWA</b>						23D. ADDRESS <b>John A. Moran, Inc. 3000 E. Balto. St.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12/29/69</b>		24C. NAME OF CEMETERY or CREMATORY <b>Balto. National Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore Maryland</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 29 1969</b>		25B. NAME OF REGISTRAR <b>Robert E. Fabel, M.D.</b>		25C. FUNERAL DIRECTOR <b>John A. Moran, Inc.</b>		ADDRESS <b>3000 E. Balto. St.</b>			

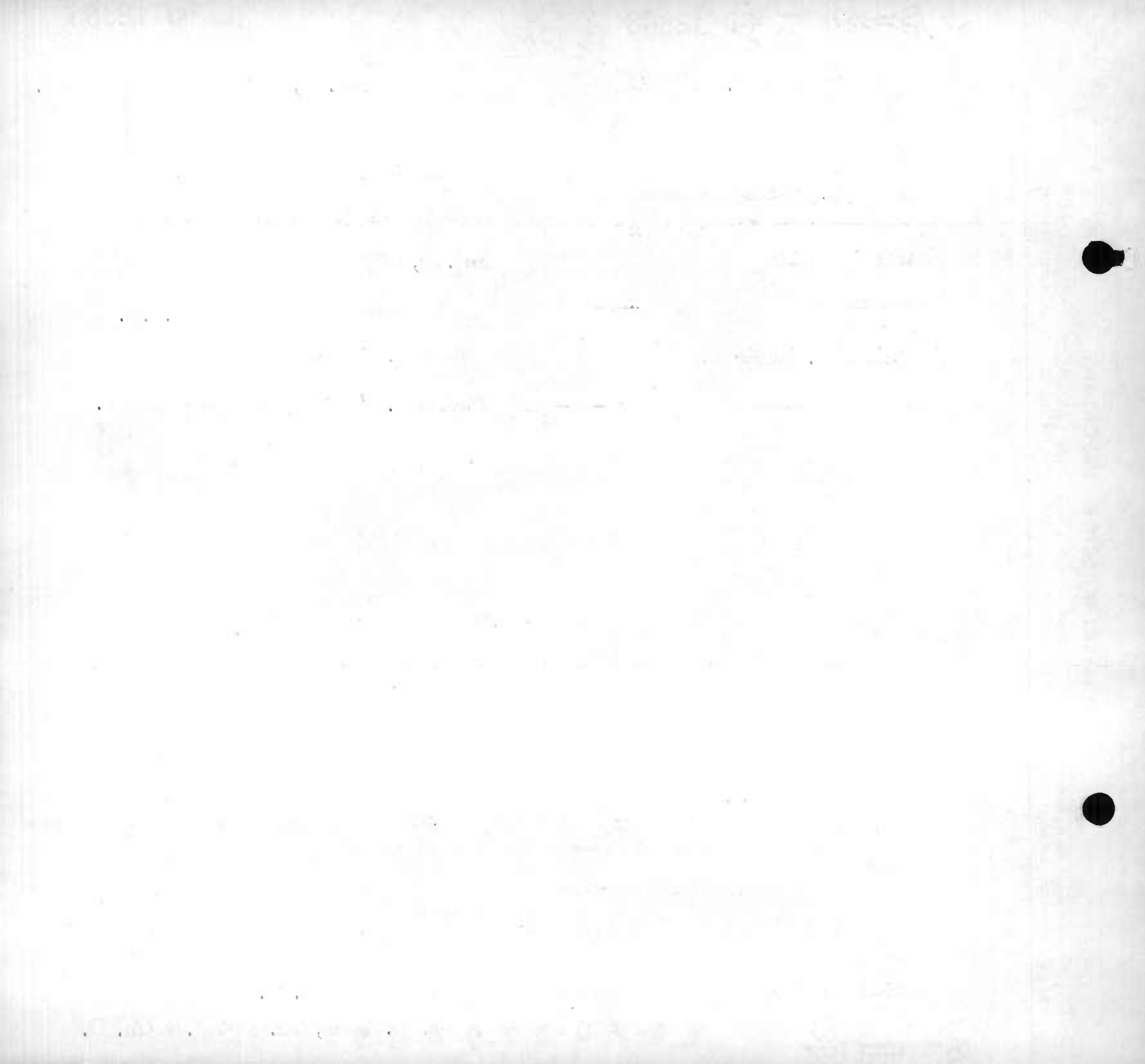
27.11.20.1

3-4

**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <b>69 12863</b>	
<b>0-540</b>		<b>69 12863</b>		<b>CERTIFICATE OF DEATH</b>	
1. NAME OF DECEASED (Type or Print) <b>Rose C. O'Neill</b>			2. DATE AND HOUR OF DEATH <b>Dec. 25, 1969</b> <b>6 P. M.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>901</b>		
FULL NAME OF HOSPITAL OR INSTITUTION <b>00 3825 Crestlyn Road</b>			C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER <b>3825 Crestlyn Road</b>		
5. SEX <b>Female</b>	6. RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 18, 1897</b>	9. AGE (In years last birthday) <b>72</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>----</b>	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>Richard A. Murphy</b>			14. MOTHER'S MAIDEN NAME <b>Rose C. Kiggins</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>210-10-0320</b>	17. INFORMANT ADDRESS <b>Thomas E. O'Neill 3825 Crestlyn Rd.</b>		
18. <b>431.9 I-250.9</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b> (A) IMMEDIATE CAUSE <b>Cerebrovascular Hemorrhage</b> DUE TO, OR AS A CONSEQUENCE OF: <b>Arteriosclerosis</b> (B) _____ DUE TO, OR AS A CONSEQUENCE OF: (C) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>Diabetes mellitus</b>					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>no</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <b>1966</b> to <b>November</b> 19 <b>69</b> , that (I) ( <del>we</del> ) last saw the deceased alive on <b>November 5,</b> 19 <b>69</b> and that in ( <del>my</del> ) (our) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>we</del> ) ( <del>did</del> ) (did not) view the body after death.					
23A. SIGNATURE <b>Melito M. Torres, M.D.</b>				23B. DATE SIGNED <b>Dec 26, 1969</b>	
23C. PHYSICIAN'S NAME (Type) <b>MELITO M. TORRES, M.D.</b>		23D. ADDRESS <b>441 S. ELLWOOD AVENUE</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>12/29/69</b>	24C. NAME of CEMETERY or CREMATORY <b>New Cathedral Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Balto. Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 29 1969</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR ADDRESS <b>John A. Moran, Inc. 3000 E. Balto. St.</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

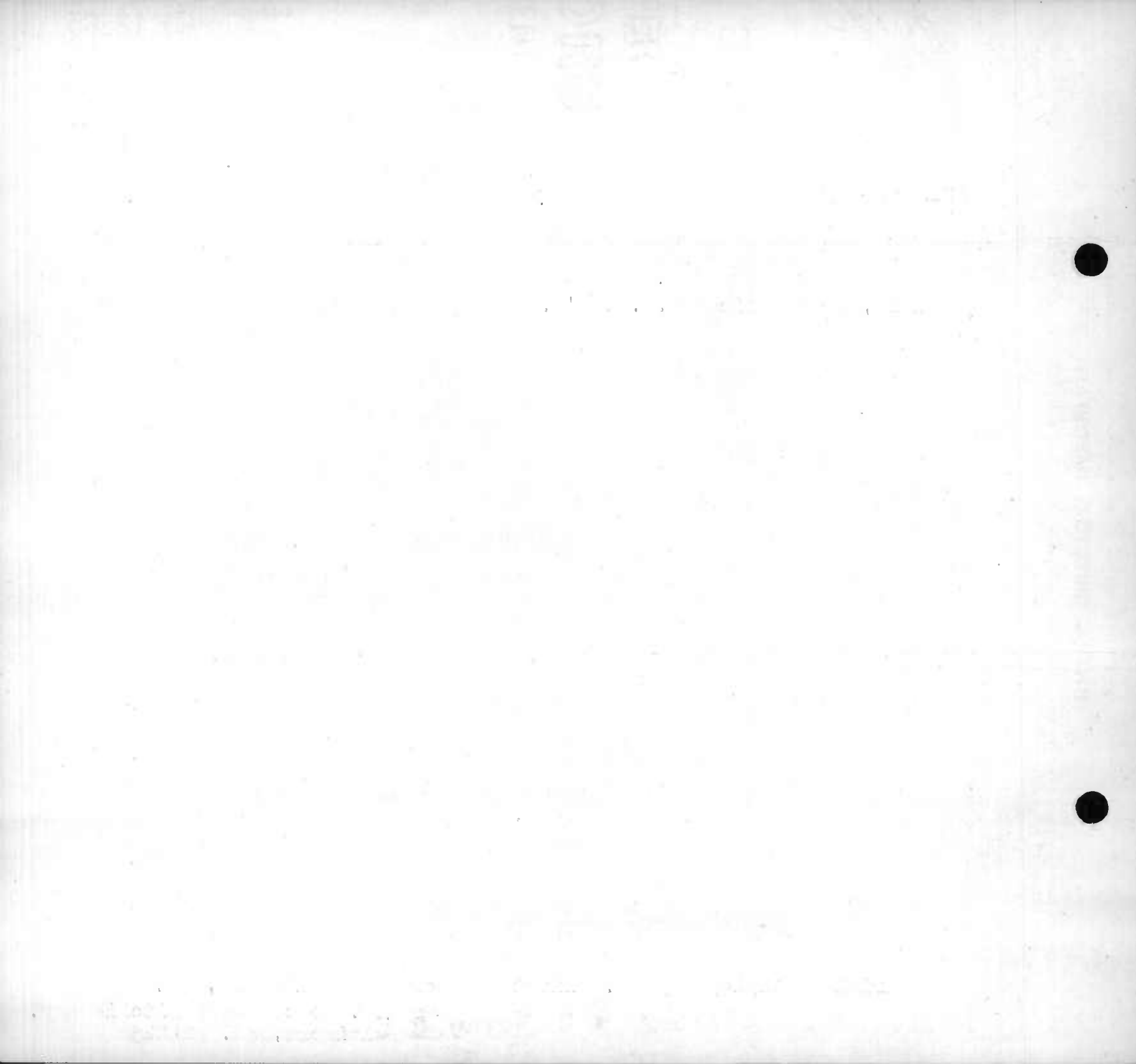
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="float: right;">69 12864</span>	
J-520 69 12864				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <i>Cassie Johns</i>		2. DATE AND HOUR OF DEATH <i>12/21/69 7:10 AM</i>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <i>South Baltimore General Hospital</i>		A. STATE <i>Maryland</i>		B. COUNTY <i>25</i>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <i>Baltimore</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <i>Female</i>		6. RACE <i>White</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <i>11/14/18</i>		9. AGE (In years last birthday) <i>51</i>		If Under 1 Yr. Months: Days: Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>NONE</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>VIRGINIA</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME <i>Amelia Johns</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>NO</i>		16. SOCIAL SECURITY NO. <i>218 22 0955</i>		17. INFORMANT <i>C1 Schyler L. Branham</i>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <i>Metastases of ovarian tumor</i>		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES		(B) DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) DUE TO, OR AS A CONSEQUENCE OF:			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <i>12-21-69</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (H) (this hospital) attended the deceased from <i>4:40 a.m. 12-21-69</i> to <i>7:10 a.m. 12-21-69</i> that (H) (we) last saw the deceased alive on <i>12-21-69</i> and that (H) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Nabil Yacoub Younan</i>		23B. DATE SIGNED <i>12-21-69</i>		23C. PHYSICIAN'S NAME (Type) <i>Younan Nabil Yacoub</i>	
23D. ADDRESS <i>South Baltimore General Hospital</i>		23E. FUNERAL DIRECTOR <i>George J. Gonce</i>		23F. ADDRESS <i>4001 Ritchie Hgy. Baltimore, Md. 21225</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>12/24/69</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Cedar Hill Cemetery</i>	
24D. LOCATION <i>Baltimore, Md.</i>		24E. DATE REC'D BY HEALTH DEPT. <i>DEC 29 1969</i>		24F. NAME OF REGISTRAR <i>Robert E. Jones</i>	

81/11/10

**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <b>69 12865</b>
M-620 <b>69 12865</b>		<b>CERTIFICATE OF DEATH</b>		
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>JOSEPH G. MEYERS</b>		
2. DATE AND HOUR OF DEATH <b>12-21-69 2:40 P.M.</b>		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>South Baltimore General Hospital</b>		
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTIMORE</b>		C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
5. SEX <b>M</b> 6. RACE <b>W</b> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		E. STREET AND NUMBER <b>3906 Leanneth St.</b>		
8. DATE OF BIRTH <b>11-28-81</b> 9. AGE (In years last birthday) <b>88 yrs.</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clerk, Post Office</b>		
10B. KIND OF BUSINESS OR INDUSTRY <b>U.S. Gov't.</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>John F. P. Meyers</b>		
14. MOTHER'S MAIDEN NAME <b>Doenges</b>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		
16. SOCIAL SECURITY NO.		17. INFORMANT <b>Maugant L. Meyers</b> ADDRESS <b>same</b>		
18. <b>285.91</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Coronary Heart Lesion</b> (B) <b>Acute Myocardial Infarction</b> (C) <b>Severe Anemia etio unknown</b>		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <b>12-20-69</b> 19 <b>69</b> to <b>12-21</b> 19 <b>69</b> , that (I) (we) last saw the deceased alive on <b>12-21-69</b> 19 <b>69</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <b>Virginia Y. Fausto, M.D.</b> DEGREE				23B. DATE SIGNED <b>12-21-69</b>
23C. PHYSICIAN'S NAME (Type) <b>VIRGINIA Y. FAUSTO, M.D.</b> DEGREE				23D. ADDRESS <b>South Baltimore General Hospital</b>
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12/24/69</b>		24C. NAME OF CEMETERY or CREMATORY <b>Mt. Olivet Cemetery</b>
24D. LOCATION <b>Baltimore, Md.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>DEC 29 1969</b>		
25B. NAME OF REGISTRAR <b>Robert E. Taylor, M.D.</b>		25C. FUNERAL DIRECTOR <b>George J. Gonce</b> ADDRESS <b>4001 Ritchie Hgy. Baltimore, Md. 21225</b>		

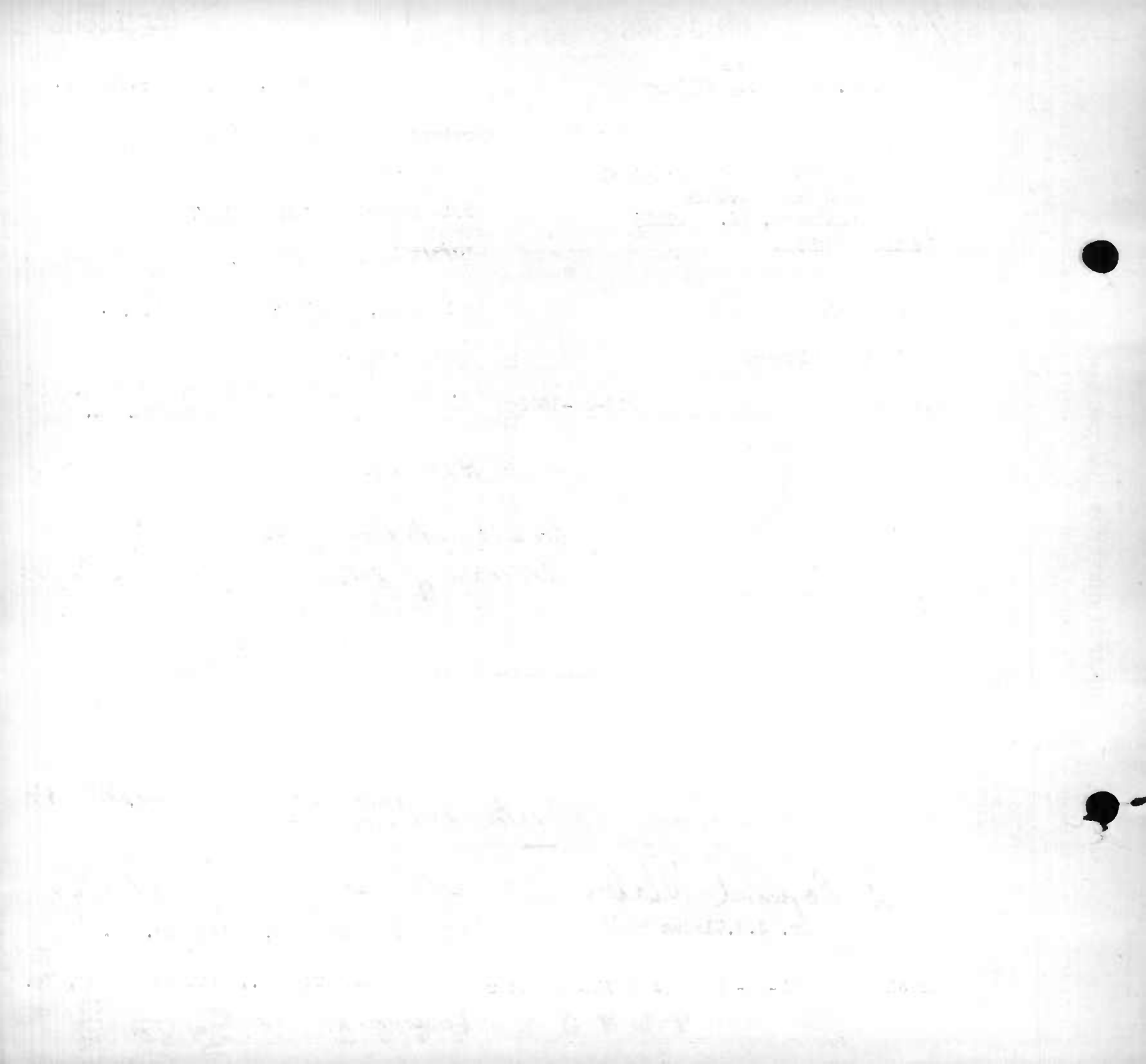




# FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="float: right;">69 12866</span>	
BIRTH NO. <span style="font-size: 2em;">H-460</span>		69 12866		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <b>Mae</b> <b>Mrs. Hilda Mae Hillary</b>			2. DATE AND HOUR OF DEATH <b>December 28, 1969</b> <b>9:24 P.</b> M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore County</b> <span style="float: right;">5300</span>		
FULL NAME OF HOSPITAL OR INSTITUTION <b>91 Jenkins Memorial Hospital</b> <b>1000 Caton Avenue</b> <b>Baltimore, Md. 21229</b>			C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
5. SEX <b>Female</b>			6. RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>
13. FATHER'S NAME <b>William Whitmore</b>			14. MOTHER'S MAIDEN NAME <b>Lydia Ritter</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Unknown</b>			16. SOCIAL SECURITY NO. <b>213-28-3802</b>		17. INFORMANT <b>Mr. Quinton Hillary, 5310 Overhill Rd. 21207</b> <b>(Son) Baltimore, Md.</b>
18. <b>1969</b> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b>			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF <b>Hypertension</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>6 hours</b>
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) <b>Occult infection pelvis</b> DUE TO, OR AS A CONSEQUENCE OF:		<b>3 weeks</b>
			(C) <b>Sarcoma of pelvis</b>		<b>2 1/2 yrs</b>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>12/28 1969</b> to <b>12/28 1969</b> , that (I) (we) last saw the deceased alive on <b>12/28 1969</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (†) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>J. Raymond Gladue</b> Dr. J.R.Gladue				23B. DATE SIGNED <b>12/29/69</b>	
23C. PHYSICIAN'S NAME (Type) <b>Dr. J.R.Gladue</b>				23D. ADDRESS <b>701 Brookwood Road, Baltimore, Md.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <b>12-31-69</b>		24C. NAME OF CEMETERY or CREMATORY <b>Lake View Cemetery</b>	
<b>Burial</b>				24D. LOCATION (City, town, or county) (State) <b>Liberty Rd., Carroll County, Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 30 1969</b>		25B. NAME OF REGISTRAR <b>Robert E. G. G. G.</b>		25C. FUNERAL DIRECTOR <b>Margaret Hubbard</b> ADDRESS <b>4107 Wilkes Ave</b>	



H-236

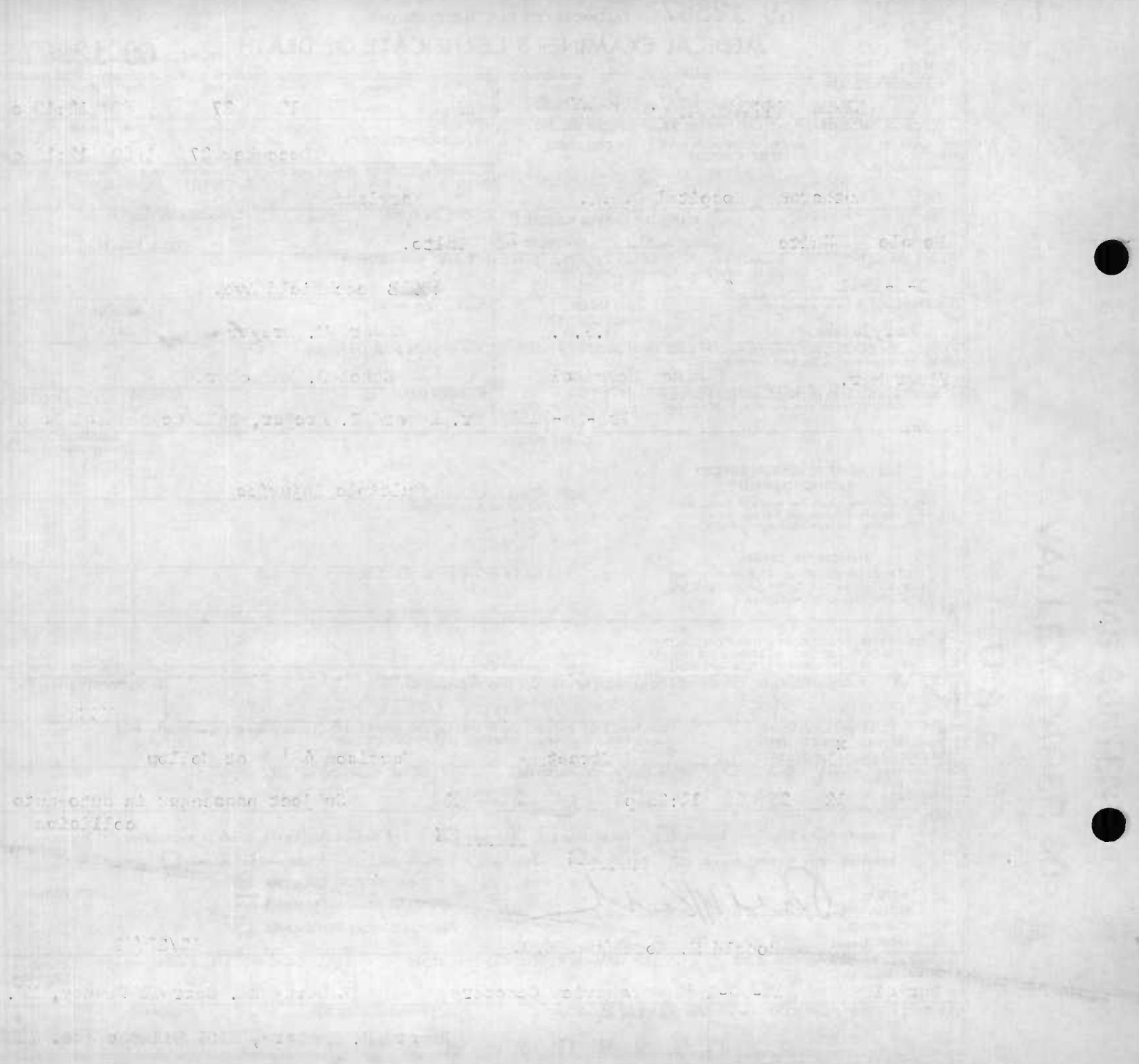
69 12867

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 69 12867

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>LINDA HECKATHORN J. HECKATHORN</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> 12 27 69 12:15 am.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>Lutheran Hospital D.O.A.</b>		3. DATE PRONOUNCED DEAD Month Day Year <b>December 27, 1969</b> 12:15 am.		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>2541</b>	
6. SEX <b>Female</b>	7. RACE <b>White</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		C. CITY OR TOWN <b>Balto.</b>	
9. DATE OF BIRTH <b>3-5-1941</b>		10. AGE (In years lost birthday) <b>28</b>		E. STREET AND NUMBER <b>409 B Beechfield Ave.</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Edward T. Dreyer</b>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Floor Mgr.</b>		14B. KIND OF BUSINESS OR INDUSTRY <b>Sinai Hospital</b>		15. MOTHER'S MAIDEN NAME <b>Ethel J. Whitchurch</b>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		17. SOCIAL SECURITY NO. <b>255-58-7132</b>		18. INFORMANT ADDRESS <b>Mr. Edward T. Dreyer, 3421 Centennial Lane</b>	
19. CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>E812.1</b>					
(A) IMMEDIATE CAUSE <b>Multiple Injuries</b> DUE TO, OR AS A CONSEQUENCE OF:					
(B) DUE TO, OR AS A CONSEQUENCE OF:					
(C) _____					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
20A. DATE OF OPERATION <b>2</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) <b>YES</b>	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Street</b>		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? <b>Garrison 48' N at Collow</b>	
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) <b>12 26 69 11:25</b>		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? <b>Subject passenger in auto-auto collision</b>	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE EXAMINER'S NAME (Type) <b>Ronald N. Kornblum, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>12/27/69</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12-30-1969</b>		24C. NAME OF CEMETERY or CREMATORY <b>Lakeview Cemetery</b>	
24D. LOCATION (City, town, or county) (State) <b>Liberty Rd. Carroll County, Md.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>DEC 30 1969</b>		25B. NAME OF REGISTRAR <b>Howard H. Hubbard</b>	
25C. FUNERAL DIRECTOR ADDRESS <b>Howard H. Hubbard, 4107 Wilkens Ave. 21229</b>					



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		X REG. NO. 69 12868	
W-426 69 12868		CERTIFICATE OF DEATH	
BIRTH NO.		2. DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print)		DECEMBER 26, 1969 5:00P M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
WALKER, CORA MARIE		A. STATE MARYLAND B. COUNTY BALTIMORE COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION		C. CITY OR TOWN	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		LANSDOWNE	
40 ST AGNES HOSPITAL		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
5. SEX		E. STREET AND NUMBER	
FEMALE		2015 HAMMONDS FERRY RD	
6. RACE		8. DATE OF BIRTH	
WHITE		02 28 98	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9. AGE (In years last birthday)	
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		71	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country)	
RETIRED		W VIRGINIA	
10B. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY?	
		U.S.A.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
JOSEPH GRAPES		LILLIAN ( Self )	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
		232 26 3005	
17. INFORMANT		ADDRESS	
		ST AGNES RECORDS-CATON & WILKENS AVE	
18. CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CH.F.	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
ANTECEDENT CAUSES		(B) Septicemia & Electrolyte imbalance.	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C)	
II			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
0			
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
NO			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. HOW DID INJURY OCCUR?	
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
22. I certify that (I) (this hospital) attended the deceased from DECEMBER 23 19 69 to DECEMBER 26 19 69 that (I) (we) last saw the deceased alive on DECEMBER 26 19 69 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE		23B. DATE SIGNED	
[Signature] AFZAL MD		12 26 69	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS	
MUHAMMAD AFZAL		ST AGNES HOSPITAL BALTO MD 21229	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE	
Burial		12-30-1969	
24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Lake View Cemetery		Liberty Rd., Carroll County, Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR	
DEC 30 1969		Robert E. Taylor, Jr.	
25C. FUNERAL DIRECTOR		ADDRESS	
Howard H. Hubbard		4107 Wilkens Ave. 21229	

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69 12869

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 69 12869

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>Ida Jones</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> Month Day Year Hour M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD (If NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>12 22 69 A. M.</b>		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>Queen Anne's 6700</b>	
6. SEX <b>Female</b>	7. RACE <b>Negro</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Chester</b>	
9. DATE OF BIRTH <b>August 9 1924</b>		10. AGE (In years lost birthday) <b>45</b>	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
12. CITIZEN OF <b>U.S.A.</b>		13. FATHER'S NAME <b>William E. Sullivan</b>		E. STREET AND NUMBER <b>Box 74 Chester Rd.</b>	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Factory</b>		15. MOTHER'S MAIDEN NAME <b>Clémentine Anderson</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>	
17. SOCIAL SECURITY NO. <b>220-26-3800</b>		18. INFORMANT <b>Paulette Cain</b>		ADDRESS <b>Box 74 Chester Md.</b>	
19. <b>4339</b>		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Cerebral Thrombosis</b>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) DUE TO, OR AS A CONSEQUENCE OF:			
(C) _____					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
20A. DATE OF OPERATION <b>2</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) <b>yes</b>	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (if in Baltimore City, give exact location) INJURY OCCUR?	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE EXAMINER'S NAME (Type)		Russell S. Fisher, M.D.		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>12-22-69</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>12/28/69</b>		24C. NAME OF CEMETERY or CREMATORY <b>Chester Cemetery</b>	
24D. LOCATION (City, town, or county) (State) <b>Chester Maryland</b>		25A. DATE REC'D BY HEALTH DEPT. <b>DEC 30 1969</b>		25B. NAME OF REGISTRAR <b>Russell S. Fisher, M.D.</b>	
25C. FUNERAL DIRECTOR <b>J.B. Dashiell</b>		ADDRESS <b>Funeral Home, Easton Md.</b>			



Letter from M.E.'s office

1-23-70

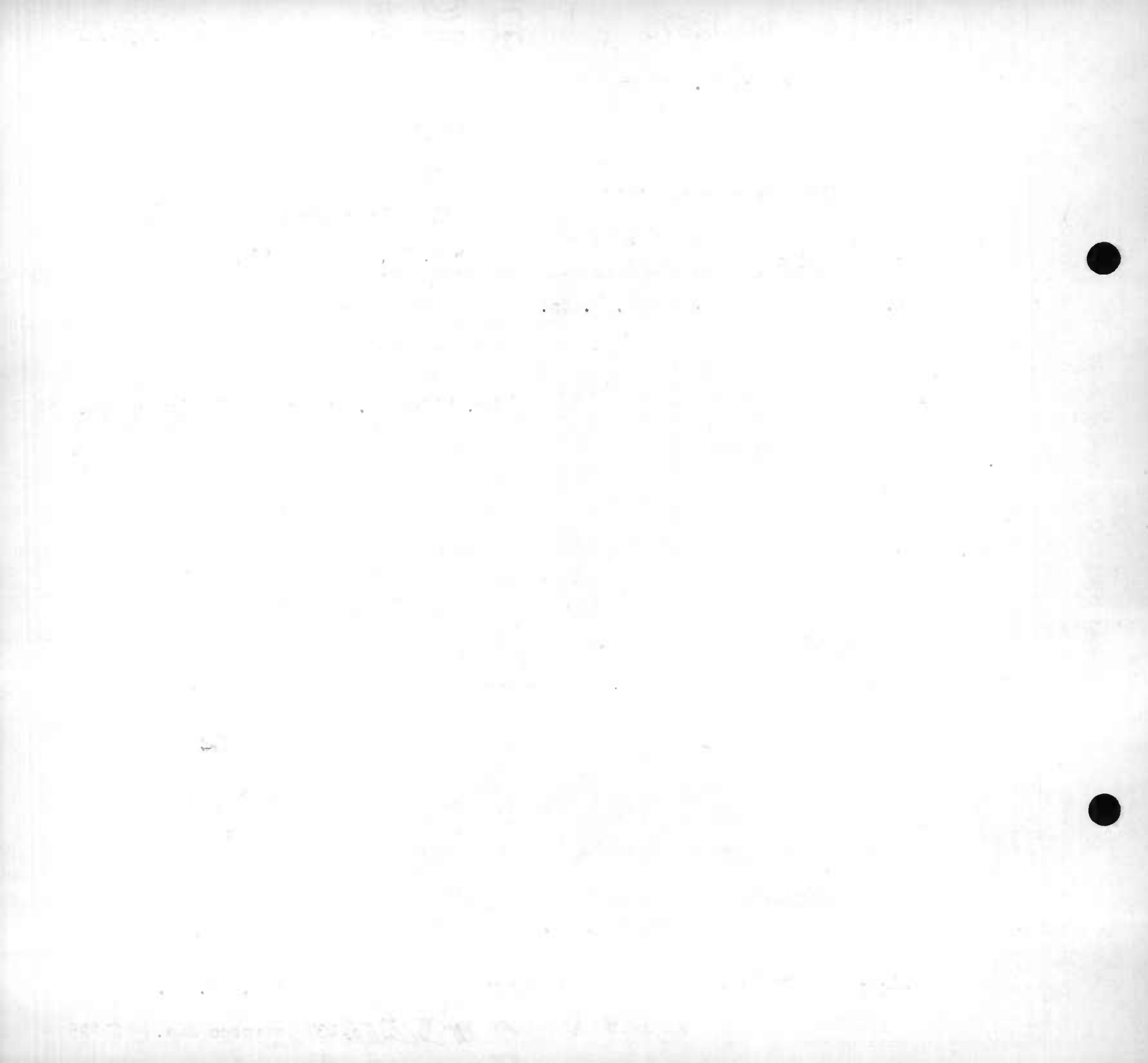
M.H.



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

17-625 69 12870		BALTIMORE CITY HEALTH DEPARTMENT <b>CERTIFICATE OF DEATH</b>		REG. NO. 69 12870	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>Robert E. Morgan</b>		2. DATE AND HOUR OF DEATH <b>12/28/69</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>2544</b>		M.	
FULL NAME OF HOSPITAL OR INSTITUTION <b>00</b>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>4109 Cleve Court 21225</b>		C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <b>4109 Cleve Court 21225</b>		5. SEX <b>Male</b>		6. RACE <b>White</b>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Sept. 13, 1896</b>		9. AGE (In years last birthday) <b>73</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Ret. Clerk</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>B &amp; O R. R. Co.</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U S</b>		13. FATHER'S NAME <b>Unk</b>		14. MOTHER'S MAIDEN NAME <b>Geneva Birch</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mr. Alfred E. Morgan</b>	
18. <b>491X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>BRONCHOPNEUMONIA</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Exacerbation of chronic bronchitis</b> <b>Three packs of 10's cigarettes</b> <b>Cor. w. h. disease</b>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>BRONCHOPNEUMONIA</b> (B) DUE TO, OR AS A CONSEQUENCE OF: <b>BRONCHITIS</b> (C) DUE TO, OR AS A CONSEQUENCE OF: <b>THREE PACKS OF 10'S CIGARETTES</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2</b>	
MEDICAL CERTIFICATION OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>Cor. w. h. disease</b>		19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) <b>0</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>8-23</b> 19 <b>69</b> to <b>12-27</b> 19 <b>69</b> , that (I) (we) last saw the deceased alive on <b>12-27</b> 19 <b>69</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>R. E. Summers</b>		23B. DATE SIGNED <b>12 29 69</b>		23C. PHYSICIAN'S NAME (Type) <b>R. E. Summers MD</b>	
23D. ADDRESS <b>1101 Calverton Ave</b>		23E. DEGREE <b>MD</b>		23F. DEGREE <b>MD</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12/31/69</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Oaklawn Cemetery</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore, Co. Md.</b>		24E. FUNERAL DIRECTOR <b>W. E. F. F.</b>		24F. ADDRESS <b>237 Patapsco Ave. 21225</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 30 1969</b>		25B. NAME OF REGISTRAR <b>W. E. F. F.</b>		25C. ADDRESS <b>237 Patapsco Ave. 21225</b>	



# FUNERAL DIRECTOR: IMPORTANT

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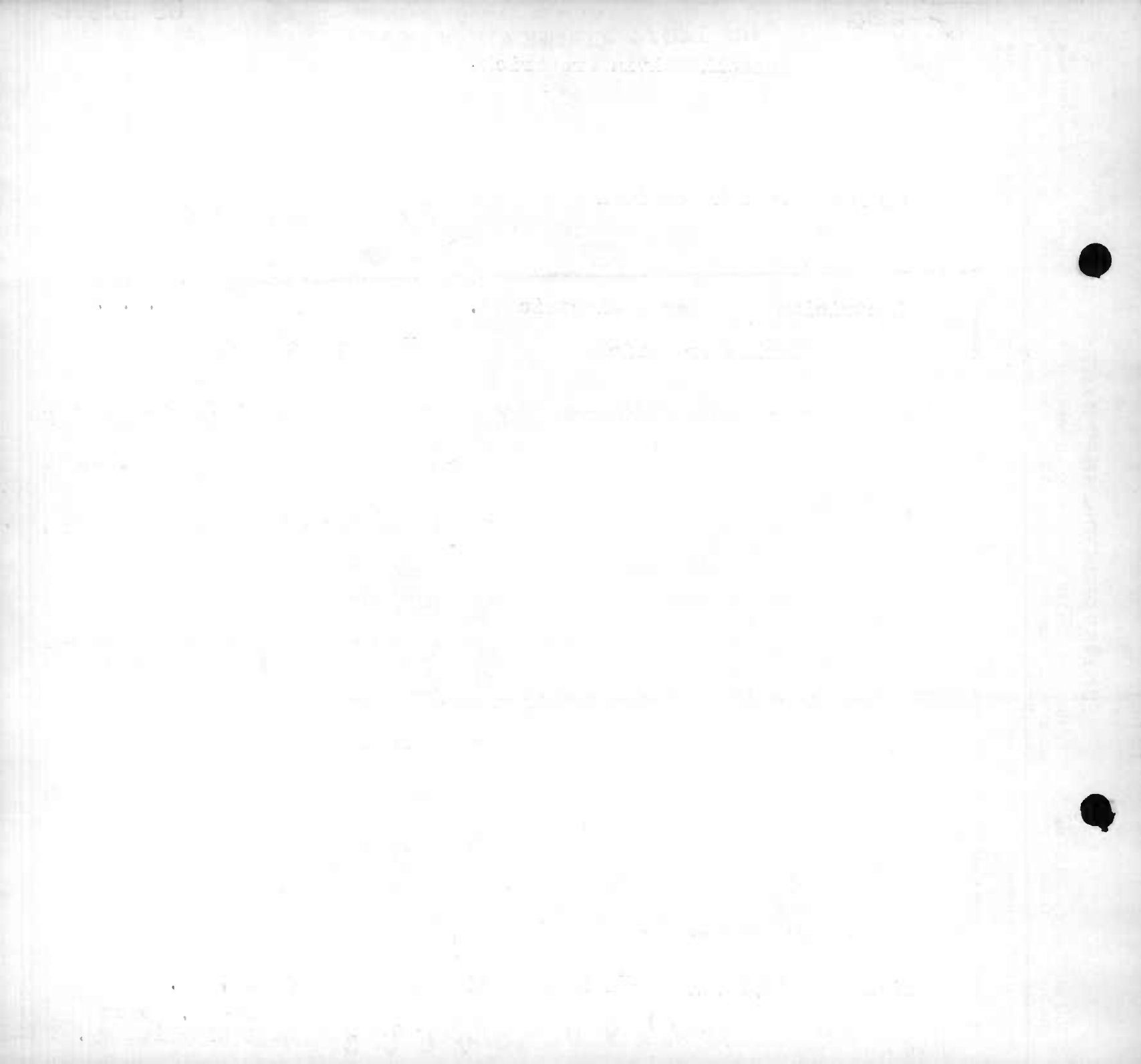
X-453		69 12871		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 69 12871	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) <u>ROLLAND, Ethel</u>			
2. DATE AND HOUR OF DEATH <u>12-26-69 08<sup>23</sup></u>				M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>2201</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>HUNH Baltimore MD</u>				C. CITY OR TOWN <u>BAITmore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				E. STREET AND NUMBER <u>6 E. HILL STREET BAITmore MD</u>			
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/4/85</u>	9. AGE (In years last birthday) <u>84</u>	10. Under 1 Yr. Months: Days	11. Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>N.C. Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>Yes</u>
13. FATHER'S NAME <u>James Turner</u>			14. MOTHER'S MAIDEN NAME <u>Emma Smith</u>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO. <u>216-03-5041</u>		17. INFORMANT <u>Mrs Ethel Albaugh 35 E Wheeling St.</u>		
18. <u>412.41</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Cerebral Artery</u> (B) <u>A.S.C.V. Disease</u> DUE TO, OR AS A CONSEQUENCE OF: (C) _____			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> <u>?</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>Glaucoma</u>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs.</u>				
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>1/23 1969</u> to <u>12/26 1969</u> , that (I) (we) last saw the deceased alive on <u>12/23 1969</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Joseph S. Blum MD</u>				23B. DATE SIGNED <u>12/26/69</u>		23C. PHYSICIAN'S NAME (Type) <u>JOSEPH S. BLUM MD</u>	
23D. ADDRESS <u>1115 N. CALVERT ST.</u>							
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>12/29/69</u>		24C. NAME of CEMETERY or CREMATORY <u>Loudon Park Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>DEC 30 1969</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor</u>		25C. FUNERAL DIRECTOR <u>JOHN F. DENNY, INC.</u>			
				ADDRESS <u>715 Light St.</u>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				69 12872	
7-636 69 12872				CERTIFICATE OF DEATH	
BIRTH NO.				Registered No.	
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print) <b>RUSSELL FREDERICKS</b>			2. DATE AND HOUR OF DEATH <b>12-27-69 8:50 P.M.</b>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>903</b>		
FULL NAME OF HOSPITAL OR INSTITUTION <b>48 Maryland General Hospital</b>			C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b>		
			D. STREET ADDRESS (If rural, give location) <b>709 VENABLE AVE.</b>		
5. SEX <b>m</b>	6. RACE <b>w</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>m</b>	8. DATE OF BIRTH <b>3-10-94</b>	9. AGE (In years last birthday) <b>75</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Electrician</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>Gas &amp; Electric Co.</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			13. FATHER'S NAME <b>Charles Fredericks</b>		
14. MOTHER'S MAIDEN NAME <b>Mary Stuart</b>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes WW I</b>		
16. SOCIAL SECURITY NO. <b>212-05-3991</b>			17. INFORMANT ADDRESS <b>WIFE - DOROTHEA FREDERICKS - SAME</b>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Pneumonia</b>			INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>		
19A. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Chronic Emphysema</b>			19B. CAUSE OF DEATH <b>Chronic Emphysema</b>		
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>Arteriosclerotic Cardiovascular Disease</b>			21. INTERVAL BETWEEN ONSET AND DEATH <b>YEARS</b>		
22A. DATE OF OPERATION <b>12-27-69</b>		22B. CONDITION FOR WHICH OPERATION WAS PERFORMED		22C. AUTOPSY? (Yes or No) <b>NO</b>	
23A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		23B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		23C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
24A. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		24B. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		24C. HOW DID INJURY OCCUR?	
25. I certify that (I) (this hospital) attended the deceased from <b>12-27-69</b> to <b>12-27-69</b> , that (I) (we) last saw the deceased alive on <b>12-27-69</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
26A. SIGNATURE <b>Angelita A. Toppa M.D.</b>				26B. DATE SIGNED <b>12-27-69</b>	
27A. PHYSICIAN'S NAME (Type) <b>ANGELITA A. TOPPA M.D.</b>				27B. ADDRESS <b>MARYLAND GEN. HOSPITAL</b>	
28A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		28B. DATE <b>12/31/69</b>		28C. NAME OF CEMETERY OR CREMATORY <b>Baltimore National</b>	
28D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>		29A. DATE REC'D BY HEALTH DEPT. <b>DEC 30 1969</b>			
29B. NAME OF REGISTRAR <b>George J. Gonce</b>		29C. FUNERAL DIRECTOR ADDRESS <b>4001 Ritchie Hgy. 21225</b>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

S-530		69 12873		BALTIMORE CITY HEALTH DEPT		CERTIFICATE OF DEATH		REG. NO. 69 12873	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>EDWARD C. SMITH</b>				2. DATE AND HOUR OF DEATH <b>DECEMBER 26, 1969 1:30 A. M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Anne Arundel Co.</b>		C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION <b>South Baltimore General Hospital</b>				E. STREET AND NUMBER <b>706 Hammonds Lane</b>					
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 5, 1904</b>	9. AGE (In years last birthday) <b>65</b>	If Under 1 Yr. Months: Days:	If Under 24 Hrs. Hours: Min.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Pipefitter</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Shipyard</b>		11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Louis Smith</b>			14. MOTHER'S MAIDEN NAME <b>Katie</b>						
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>217 22 7916</b>		17. INFORMANT <b>Mrs. Anna J. Smith</b>		ADDRESS <b>Same</b>			
18. <b>412-21</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Cardio-Vascular Disease</b>				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Hypertension</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1-2 yr</b>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b>				(B) DUE TO, OR AS A CONSEQUENCE OF: <b>Arterio-Sclerosis</b>		<b>5-6 yr</b>			
				(C) <b>Arterio-Sclerosis</b>		<b>6-8 yr</b>			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).									
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <b>1940</b> to <b>12/26</b> <b>1969</b> , that (I) (we) last saw the deceased alive on <b>12/25</b> <b>1969</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <b>Chas. L. Ball</b>				Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <b>12/29/69</b>			
23C. PHYSICIAN'S NAME (Type) <b>Chas. L. Ball</b>				23D. ADDRESS <b>203 W. Maple Rd. Linthicum, Md.</b>					
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12/30/69</b>		24C. NAME of CEMETERY or CREMATORY <b>Holy Cross</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 30 1969</b>		25B. NAME OF REGISTRAR <b>John E. Gonce</b>		25C. FUNERAL DIRECTOR <b>George J. Gonce</b>		ADDRESS <b>4001 Ritchie Hgy. Baltimore, Md. 21225</b>			

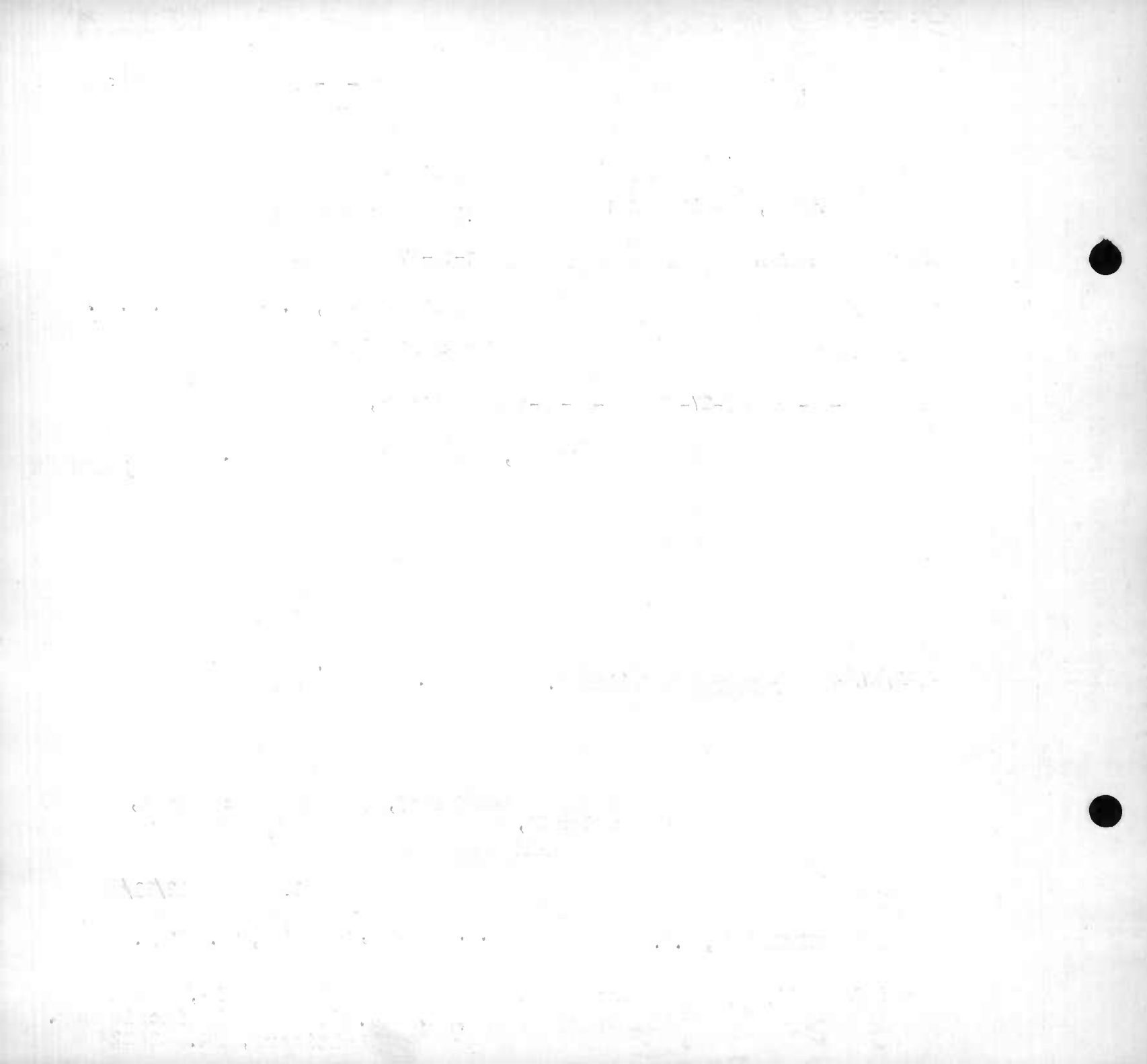




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<div style="display: flex; justify-content: space-between;"> <span><b>G-536</b></span> <span><b>69 12874</b></span> </div>		<b>BALTIMORE CITY HEALTH DEPARTMENT</b> <b>CERTIFICATE OF DEATH</b>		<b>REG. NO. 69 12874</b>									
<b>BIRTH NO.</b> 1. NAME OF DECEASED (Type or Print) <b>GUNTER, Richard Duane</b>						2. DATE AND HOUR OF DEATH <b>12-22-69 10:30 P.M.</b>							
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>23 Veterans Administration Hospital</b> <b>3900 Loch Raven Boulevard</b> <b>Baltimore, Maryland 21218</b>						4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>2505</b> C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>1330 Pontiac Avenue</b>							
5. SEX <b>Male</b>		6. RACE <b>Caucasian</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>1-18-47</b>		9. AGE (In years last birthday) <b>22</b>		If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Sheet Rock</b>				10B. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) <b>Webster County, W. Va</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>			
13. FATHER'S NAME <b>Dewey Gunter</b>						14. MOTHER'S MAIDEN NAME <b>Katherine McClean</b>							
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes 3-26-66 to 3-27-68</b>				16. SOCIAL SECURITY NO. <b>216-48-83-18</b>		17. INFORMANT <b>VA Hospital Records</b> <b>Baltimore, Maryland 21218</b>				ADDRESS			
18. <b>4387 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  <b>INCREASED INTRACRANIAL PRESSURE, SECONDARY TO BRAIN EDEMA.</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:  (B) DUE TO, OR AS A CONSEQUENCE OF:  (C)						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  <b>5 DAYS</b>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).													
19A. DATE OF OPERATION <b>12/17/69</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>INCREASED INTRACRANIAL PRESSURE.</b>		20A. AUTOPSY? (Yes or No) <b>NO.</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?							
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)							
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?							
22. I certify that <del>XX</del> (this hospital) attended the deceased from <b>December 15, 1969</b> to <b>December 22, 1969</b> , that <del>XX</del> (we) lost saw the deceased alive on <b>December 22, 1969</b> and that in <del>XX</del> (our) opinion death occurred on the date and hour and from the causes stated above. <b>XX</b> (We) (did) ( <del>did not</del> ) view the body after death.													
23A. SIGNATURE  <b>HAMID MEHDIZADEH, M.D.</b>								23B. DATE SIGNED <b>12/23/69</b>		23C. PHYSICIAN'S NAME (Type) <b>HAMID MEHDIZADEH, M.D.</b>		23D. ADDRESS <b>3900 LOCH RAVEN BOULEVARD, V.A. HOSPITAL, BALTIMORE, MD. 21218.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12/26/69</b>		24C. NAME OF CEMETERY or CREMATORY <b>Glen Haven</b>		24D. LOCATION (City, town, or county) (State) <b>Glen Burnie, Maryland</b>		25A. DATE REC'D BY HEALTH DEPT. <b>DEC 30 1969</b>					
25B. NAME OF REGISTRAR <b>George J. Gonce</b>				25C. FUNERAL DIRECTOR <b>George J. Gonce</b>				ADDRESS <b>4001 Ritchie Hgy. Baltimore, Md. 21225</b>					



R-000

69 12875

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 69 12875

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

DORIS ROW

2. DATE  
OF  
DEATHKnown ☐  
Estimated ☐Month  
Day

Year

Hour

12

23

69

6:30p M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL  
OR INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)3. DATE  
PRONOUNCED DEADMonth  
Day

Year

Hour

December 23, 1969

6:30 p M.

5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE

B. COUNTY

Maryland

1101

6. SEX

Female

7. RACE

White

8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

C. CITY OR TOWN

Balto.

D. INSIDE CITY LIMITS?

YES ☐NO ☐

9. DATE OF BIRTH

1925

10. AGE (In years  
last birthday)

44

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.

E. STREET AND NUMBER

929 N. Calvert St.

11. BIRTHPLACE (State or foreign country)

Md.

12. CITIZEN OF  
WHAT COUNTRY?

USA

13. FATHER'S NAME

UNKNOWN

14A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

UNKNOWN

16. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

None

17. SOCIAL  
SECURITY NO.

18. INFORMANT

ADDRESS

19.

571.8 I

CAUSE OF DEATH

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)(A) IMMEDIATE CAUSE Fatty metamorphosis of the liver  
DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.(B) \_\_\_\_\_  
DUE TO, OR AS A CONSEQUENCE OF:

(C) \_\_\_\_\_

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART 1 (A).

MEDICAL CERTIFICATION

20A. DATE OF OPERATION 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

No

22A. EXTERNAL CAUSE WAS  
UNDERLYING ☐ OR CONTRIB-  
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY  
(APPROX.)

22E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE

EXAMINER'S

NAME (Type) Ronald N. Kornblum, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

12/24/69

24A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

12-27-69

24C. NAME OF CEMETERY or CREMATORY

Parkwood Cem.

24D. LOCATION

(City, town, or county)

(State)

Balto. Co. Md.

25A. DATE REC'D BY HEALTH DEPT.

DEC 30 1969

25B. NAME OF REGISTRAR

Robert E. Taylor

25C. FUNERAL DIRECTOR

Wm. J. Tiekner &amp; Sons

ADDRESS

Balto, Md.

10-11-60

MEMORANDUM FOR THE RECORD

TO : SAC, NEW YORK (100-388610)

FROM : SAC, NEW YORK (100-388610)

SUBJECT: [Illegible]

RE: [Illegible]

1. [Illegible]

2. [Illegible]

3. [Illegible]

4. [Illegible]

5. [Illegible]

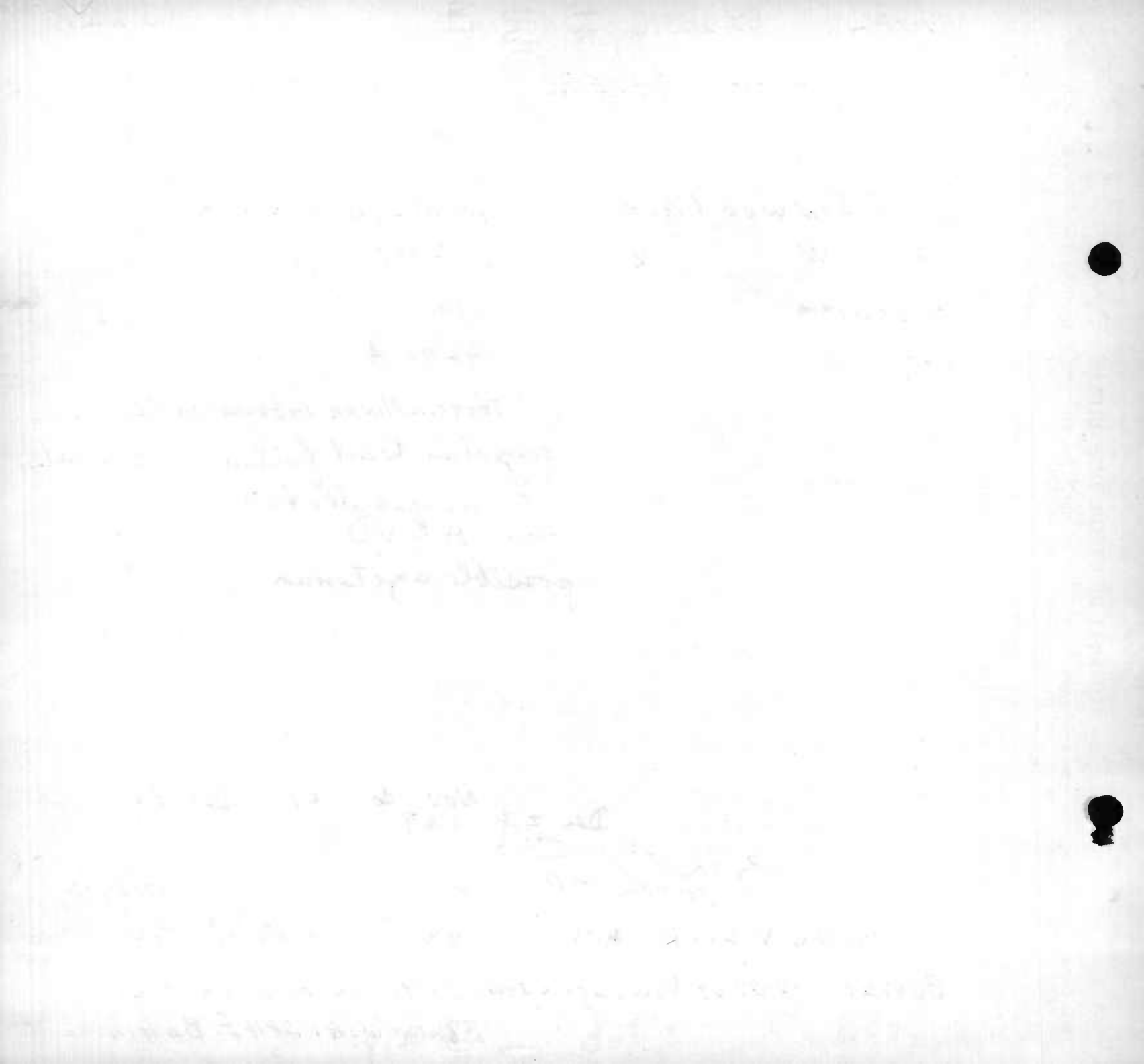
6. [Illegible]

7. [Illegible]

**FUNERAL DIRECTOR: IMPORTANT**

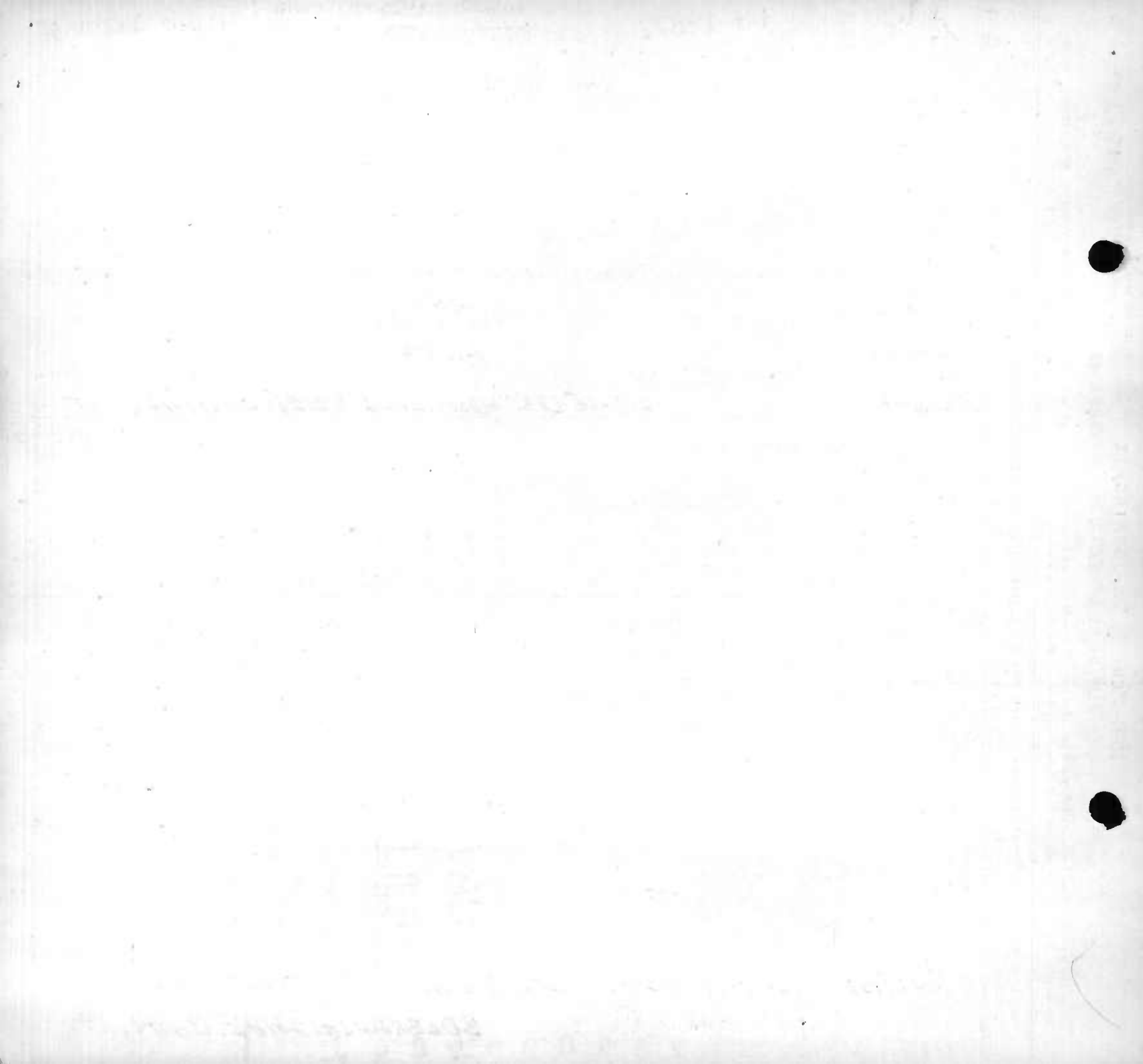
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

69 12876 BALTIMORE CITY HEALTH DEPARTMENT REG. NO. <span style="float: right;">69 12876</span>	
BIRTH NO. <span style="float: right;">M-162</span>	
1. NAME OF DECEASED (Type or Print) <span style="float: right;">SARAH MAVERS</span>	
2. DATE AND HOUR OF DEATH <span style="float: right;">DEC. 24, 1969</span>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD	
4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <span style="float: right;">MD</span> B. COUNTY <span style="float: right;">601</span>	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <span style="float: right;">00</span>	
C. CITY OR TOWN: <span style="float: right;">BALTIMORE</span> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <span style="float: right;">100 N. LINWOOD AVE</span>	
5. SEX <span style="float: right;">F</span>	6. RACE <span style="float: right;">W</span>
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <span style="float: right;">1-5-1891</span>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. AGE (In years lost birthday) <span style="float: right;">98</span>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	11. BIRTHPLACE (State or foreign country)
<span style="float: right;">Housewife</span>	<span style="float: right;">MD.</span>
13. FATHER'S NAME <span style="float: right;">PATRICK</span>	14. MOTHER'S MAIDEN NAME <span style="float: right;">MAYBY A.</span>
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.
	17. INFORMANT ADDRESS <span style="float: right;">The REID Miner 14604 Wood Rd.</span>
18. <span style="float: right;">412.41</span> CAUSE OF DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.	
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <span style="float: right;">congestive heart failure</span>	
(B) <span style="float: right;">severe A.C.V.D</span> DUE TO, OR AS A CONSEQUENCE OF: <span style="float: right;">aur fibrillation</span>	
(C) <span style="float: right;">possible azotemia</span>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).	
19A. DATE OF OPERATION <span style="float: right;">0</span>	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>
21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <span style="float: right;">Nov 20</span> 19 <span style="float: right;">69</span> to <span style="float: right;">Dec 24</span> 19 <span style="float: right;">69</span> , that (I) (we) last saw the deceased alive on <span style="float: right;">Dec 23</span> 19 <span style="float: right;">69</span> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.	
23A. SIGNATURE <span style="float: right;">B. V. Lock and</span>	23B. DATE SIGNED <span style="float: right;">12/29/69</span>
23C. PHYSICIAN'S NAME (Type) <span style="float: right;">BURTON V. LOCK M.D.</span>	23D. ADDRESS <span style="float: right;">2936 E. Baltimore St. Baltimore Md 21204</span>
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE <span style="float: right;">12-27-69</span>
24C. NAME OF CEMETERY OR CREMATORY <span style="float: right;">New Cathedral Cem.</span>	24D. LOCATION (City, town, or county) <span style="float: right;">BALTIMORE MD</span>
25A. DATE REC'D BY HEALTH DEPT. <span style="float: right;">DEC 30 1969</span>	25B. NAME OF REGISTRAR <span style="float: right;">Robert E. Fisher, M.D.</span>
25C. FUNERAL DIRECTOR <span style="float: right;">B. D. Anderson</span>	25D. ADDRESS <span style="float: right;">2816 E. Baltimore St.</span>



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

17-163		69 12877		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. MAYFORD 12877	
BIRTH NO.				12 03 16			
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
MAYFORD, Henry (McFARTH)				12/24/69		3:00 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION The Johns Hopkins Hospital				A. STATE Maryland		B. COUNTY 2610	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 3222 E. Baltimore Street			
5. SEX Male	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/03/16	9. AGE (In years last birthday) 53	If Under 1 Yr. Months: Days: Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Welder			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME HENRY			14. MOTHER'S MAIDEN NAME ANNA				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) WW-2			16. SOCIAL SECURITY NO. 217-06-1863		17. INFORMANT MRS. M. Lind 3212 E. Baltimore St.		
18. 303.21 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.			CAUSE OF DEATH (A) IMMEDIATE CAUSE Intracerebral bleed DUE TO, OR AS A CONSEQUENCE OF: (B) ? Chronic Ethanolism DUE TO, OR AS A CONSEQUENCE OF: (C) Infection				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 12/22/69 19 to 12/24/69 19, that (I) (we) last saw the deceased alive on 12/24/69 and that (n) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE March 1969				23B. DATE SIGNED 12/24			
23C. PHYSICIAN'S NAME (Type) March 1969				23D. ADDRESS J H H Johns Hopkins Hosp.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12-29-69		24C. NAME OF CEMETERY or CREMATORY BALTO. NATL. Cem.		24D. LOCATION (City, town, or county) (State) Baltimore Md.	
25A. DATE REC'D BY HEALTH DEPT. DEC 30 1969		25B. NAME OF REGISTRAR Robert E. Sailer, M.D.		25C. FUNERAL DIRECTOR B D A BROWSKI 2414 E. BALTO. ST.		ADDRESS	





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-530		69 12878		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 69 12878	
BIRTH NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>VINCENZIA BONADIO</b>				2. DATE AND HOUR OF DEATH <b>DEC. 27, 1969</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MD.</b> B. COUNTY <b>602</b>			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>140 N. Kenwood Ave.</b>				C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <b>F</b> 6. RACE <b>W</b> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH <b>2-1-1874</b>		9. AGE (In years last birthday) <b>95</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Italy.</b>	
13. FATHER'S NAME <b>Clemente</b>				14. MOTHER'S MAIDEN NAME <b>Anna</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>—</b>				16. SOCIAL SECURITY NO. <b>—</b>		17. INFORMANT <b>Michael Bonadio</b>	
18. <b>174X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Cardiac Decompensation</b> (B) <b>metastatic carcinoma</b> (C) <b>Carcinoma l. breast.</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b> <b>6 mos.</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>Nov 6</b> 19 <b>69</b> to <b>19</b> 19 <b>69</b> that (I) (we) last saw the deceased alive on <b>Dec 27</b> 19 <b>69</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Charles C. MacMinn M.D.</b>				23B. DATE SIGNED <b>December 29, 1969</b>		23C. PHYSICIAN'S NAME (Type) <b>Charles C. MacMinn, M. D.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>				24B. DATE <b>12-30-69</b>		24C. NAME OF CEMETERY or CREMATORY <b>Holy Redeemer Chrch. Baltimore Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 30 1969</b>				25B. NAME OF REGISTRAR <b>Robert E. [illegible]</b>		25C. FUNERAL DIRECTOR <b>B. Deobrowski</b>	
25D. ADDRESS <b>2900 E. Baltimore Street</b>				25E. ADDRESS <b>2818 E. Baltimore St.</b>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 69 12879	
M-520 69 12879		BIRTH NO.			
1. NAME OF DECEASED (Type or Print) Wesley E. Monk			2. DATE AND HOUR OF DEATH Dec. 29, 1969		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION 33 Johns Hopkins Hosp			A. STATE B. COUNTY 2629 E. Oliver St.		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			C. CITY OR TOWN Baltimore Md.		
			D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
			E. STREET AND NUMBER 2629 E. Oliver St.		
5. SEX Male	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 9, 1908	9. AGE (In years last birthday) 61	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) S.S. Employee		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Portsmouth Ohio		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME Wesley Monk			14. MOTHER'S MAIDEN NAME Ruth Kerhendoll		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) -- --		16. SOCIAL SECURITY NO. 234-07-6041	17. INFORMANT ADDRESS Mrs. Ethel M. Monk 2629 E. Oliver St.		
18. 410.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Myocardial Infarction (B) Hypertension C.V.D. (C) Pulmonary embolism		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 wks 10 yrs 4 yrs
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION O		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 11/1 1938 to 12/27 1969, that (I) (we) last saw the deceased alive on 12/27 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE S.C. Feldman			23B. DATE SIGNED 12/30/69		
23C. PHYSICIAN'S NAME (Type) S.C. Feldman			23D. ADDRESS 1440 G Belts St		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE Jan 2, 1970		24C. NAME OF CEMETERY or CREMATORY Baltimore Cem.	
24D. LOCATION Balto. Md.		24E. NAME OF REGISTRAR Robert E. J. J. J.		24F. FUNERAL DIRECTOR Philip Herwig Sons	
25A. DATE REC'D BY HEALTH DEPT. DEC 30 1969		25B. NAME OF REGISTRAR Robert E. J. J. J.		25C. FUNERAL DIRECTOR Philip Herwig Sons	
25D. ADDRESS 2024 Orleans St.					

—

K-125		69 12880		BALTIMORE CITY HEALTH DEPARTMENT		MEDICAL EXAMINER'S CERTIFICATE OF DEATH		REG. NO. 69 12880	
BIRTH NO.									
1. NAME OF DECEASED (Type or Print) <b>(Kopczenski)</b> <b>DANIEL J. KOPCZYNSKI</b>					2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.				
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>35 Church Home &amp; Hospital</b>					3. DATE PRONOUNCED DEAD Month Day Year Hour <b>12 29 69 2:35 A.M.</b>				
5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>104</b>									
6. SEX <b>Male</b>	7. RACE <b>White</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Balto.</b>			D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
9. DATE OF BIRTH <b>Sept. 25, 1926</b>		10. AGE (In years lost birthday) <b>43</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		13. FATHER'S NAME <b>Walter Kopczenski</b>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Longshoreman</b>		14B. KIND OF BUSINESS OR INDUSTRY <b>Stevedoring</b>		15. MOTHER'S MAIDEN NAME <b>Stella E. Struzykowski</b>					
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes W. W. II</b>		17. SOCIAL SECURITY NO. <b>219-18-7377</b>		18. INFORMANT ADDRESS <b>Alice Kopczenski - 2310 Cambridge St. #21224</b>					
19. <b>412.41</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>Arteriosclerotic cardiovascular disease</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.					(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:				
					(B) DUE TO, OR AS A CONSEQUENCE OF:				
					(C) DUE TO, OR AS A CONSEQUENCE OF:				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).									
20A. DATE OF OPERATION <b>0</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED			21. AUTOPSY? (Yes or No) <b>no</b>				
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (if in Baltimore City, give exact location) INJURY OCCUR?					
22D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?					
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE EXAMINER'S NAME (Type) <b>Russell S. Fisher, M.D.</b>		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <b>12-29-69</b>					
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1/2/70</b>		24C. NAME OF CEMETERY or CREMATORY <b>St. Stanislaus Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 30 1969</b>		25B. NAME OF REGISTRAR <b>Robert E. Fisher, M.D.</b>		25C. FUNERAL DIRECTOR ADDRESS <b>George A. Weber - 705 S. Ann St. #21231</b>					

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

K-200 1

BALTIMORE CITY HEALTH DEPARTMENT

69 12881 CERTIFICATE OF DEATH

REG. NO.

69 12881

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

WALTER VERNON KEYS.

2. DATE AND HOUR OF DEATH

12-23-69 3:20 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

UNIVERSITY OF MARYLAND HOSP BALTO. MD 21201

4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission)

A. STATE MD B. COUNTY CARROLL SPRINGFIELD STATE HOSPITAL

C. CITY OR TOWN

D. INSIDE CITY LIMITS?

YES ☐ NO ☒

E. STREET AND NUMBER

5600

5. SEX

6. RACE

7. MARRIED ☒ NEVER MARRIED ☒

WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

9. AGE (in years last birthday)

If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT COUNTRY?

UNK

UNK

UNK

USA

13. FATHER'S NAME

WILLIAM KEYS.

14. MOTHER'S MAIDEN NAME

MARY ?

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

yes World War 2

16. SOCIAL SECURITY NO.

UNK

17. INFORMANT

ADDRESS

SPRINGFIELD STATE HOSP.

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

RESPIRATORY DEPRESS.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

2-5 MIN

12-16 to 12-23 1969

(B) DUE TO, OR AS A CONSEQUENCE OF:

CVA, IATROGENIC CA TONSIL, L.

(C) DUE TO, OR AS A CONSEQUENCE OF:

HEMORRHAGE FROM

FROM

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

12-16-69

HEMORRHAGE FROM METAS CA

NO

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)

21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (1) (this hospital) attended the deceased from 12-16 1969 to 12-23 1969 that (1) (we) last saw the deceased alive on 12-23 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Arthur M. LaBruce MD

Attending Phys. ☐

Med. Director ☐

Staff Phys. ☒

23B. DATE SIGNED

12-23-69 3:35 PM

24C. PHYSICIAN'S NAME (Type)

ARTHUR M. LABRUCHE M.D.

23D. ADDRESS

UNIVERSITY OF MD. HOSP.

24A. BURIAL, CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME of CEMETERY or CREMATORY

24D. LOCATION (City, town, or county) (State)

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

DEC 30 1969

Robert E. Fisher, M.D.

John R. Hagerston Jr. Hagerston Md





1  
B-435

69 12882

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

69 12882

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

JAMES BALTIMORE

2. DATE  
OF  
DEATHKnown ☐ Estimated ☐

Month

Day

Year

Hour

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL  
OR INSTITUTION(If not in hospital or institution, give street  
address or location)

PROVIDENT HOSPITAL (DOA)

3. DATE  
PRONOUNCED DEAD

Month

Day

Year

Hour

December 20, 1969

7:25 A. M.

5. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)

A. STATE

B. COUNTY

Maryland

1501

6. SEX

Male

7. RACE

Negro

B. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☐NO ☐

9. DATE OF BIRTH

Apr. 1, 1936

10. AGE (In years  
last birthday)

33

# Under 1 Yr. If Under 24 Hrs.  
Months: Days: Hours: Min.

E. STREET AND NUMBER

1320 N. Fremont Avenue

11. BIRTHPLACE (State or foreign country)

Hagerstown Md

12. CITIZEN OF  
WHAT COUNTRY?

USA

13. FATHER'S NAME

Cecil Baltimore

14A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Laborer

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Helen Bulter

16. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

yes

17. SOCIAL  
SECURITY NO.

215-34-3872

18. INFORMANT

Cecil Baltimore 119 Clarkson Ave  
Hagerstown Md.

ADDRESS

19.

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

CAUSE OF DEATH

Stab wound of right chest

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

MEDICAL CERTIFICATION

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART I (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

yes

22A. EXTERNAL CAUSE WAS  
UNDERLYING ☒ OR CONTRIB-  
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg., etc.)

Street

22C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?

1300 Block Fremont Avenue

22D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY  
(APPROX.) 12-20-69 7:10 A. m.

22E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☒

22F. HOW DID INJURY OCCUR?

Stabbed during altercation

23.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐ACTUAL  
SIGNATUREEXAMINER'S  
NAME (Type)

Isidore Mihalakis, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

12/20/69

24A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

12-30-69

24C. NAME of CEMETERY or CREMATORY

National Cemetery

24D. LOCATION (City, town, or county)

Gettysburg, Pa.

(State)

25A. DATE REC'D BY HEALTH DEPT.

DEC 30 1969

25B. NAME OF REGISTRAR

R. E. Faber, M.D.

25C. FUNERAL DIRECTOR

John B. Watson, Jr. Hagerstown md

ADDRESS

*[Handwritten signature]*

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

## CERTIFICATE OF DEATH

REG. NO.

69 12883

BIRTH NO.

69 12883

1. NAME OF DECEASED  
(Type or Print)

LAURA B. Buffington

2. DATE AND HOUR OF DEATH

12/26/69 6:50 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

44 Union Memorial Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission)  
A. STATE B. COUNTY

MD

1348

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒ NO ☐

E. STREET AND NUMBER

1410 Delwood Ave.

5. SEX

F

6. RACE

W

7. MARRIED ☐NEVER MARRIED ☐WIDOWED ☒DIVORCED ☐

8. DATE OF BIRTH

10/27/22

9. AGE (in years  
last birthday)

87

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

MD

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

?

14. MOTHER'S MAIDEN NAME

?

15. Was Deceased Ever in U. S. Armed Forces?  
(Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Leona P. Livingston 1410 Delwood Ave.

18. 41241

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

CARDIAC FAILURE

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

2 days

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving  
rise to the above cause (A) stating the  
UNDERLYING CONDITION last.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

ASCVD

(C)

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART I (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING  
OR CONTRIBUTING CAUSE OF  
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME  
OF INJURY  
(APPROX.)

21E. INJURY OCCURRED

While At ☐ Not While  
Work At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 12/25/1969 to 12/26/1969  
that (I) (we) last saw the deceased alive on 12/26/1969 and that in (my) (our) opinion death occurred on the date  
and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Donald V. Fisher MD

Attending  
Phys. ☐Med.  
Director ☐Staff  
Phys. ☒

23B. DATE SIGNED

12/26/69

23C. PHYSICIAN'S  
NAME (Type)

23D. ADDRESS

DEGREE

24A. BURIAL CREMATION,  
REMOVAL (Specify)

24B. DATE

24C. NAME of CEMETERY or CREMATORY

24D. LOCATION

(City, town, or county)

(State)

Burial

12/29/69

Morgan Chapel

Canall Co.

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

DEC 30 1969

Robert E. Taylor R.D.

Paul E. Eshenrich 3615 Chestnut Ave.

1000 1000 1000

1000 1000 1000

1000

1000

1000 1000 1000

1000

1000

1000

1000

1000

1000

1000

1000

1000 1000 1000

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 69 12884	
69 12884				CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		STAFFORD, CLAUDE M.		12-25-69 9:15 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION 42 SINAI HOSPITAL OF BALTO.			A. STATE MARYLAND		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER 610 W. 36th ST. #1		
5. SEX M	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-26-88	9. AGE (in years last birthday) 81	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) POLICE		10B. KIND OF BUSINESS OR INDUSTRY BALTO. CITY		11. BIRTHPLACE (State or foreign country) MD	
13. FATHER'S NAME ?			12. CITIZEN OF WHAT COUNTRY?		
14. MOTHER'S MAIDEN NAME ?					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO.		17. INFORMANT JOHN O. STAFFORD 4224 ELSA TERRACE	
18. 412.41 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) DIPLOCOCCO PNEUMONIA			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH days		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: A. S. C. V. D. (B) DUE TO, OR AS A CONSEQUENCE OF: years (C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 6		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (initially medical examined)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from 12-22 1969 to 12-25 1969 that (I) (we) last saw the deceased alive on 12-25 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE H. H. Allen M.D. 9128			23B. DATE SIGNED 12-25-69		23C. PHYSICIAN'S NAME (Type) CARLOS S. VALLEJOS M.D.
23D. ADDRESS SINAI HOSP. OF BALTO.			24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		
24B. DATE 12/29/69			24C. NAME OF CEMETERY OR CREMATORY WOOD LAWN		
24D. LOCATION BALTO. MD.			25A. DATE REC'D BY HEALTH DEPT. DEC 30 1969		
25B. NAME OF REGISTRAR R. E. Valley, M.D.			25C. FUNERAL DIRECTOR R. E. Valley, M.D.		
25D. ADDRESS 3617 Chestnut Ave.					

Paul C. Venable  
3615 Chestnut Ave.

BRICK 15' x 10' WOOD LAM  
CARLOS E. VALLEJO M.D. SINAI HOSP. OF BALTO.  
BALTO. MD.

19-52-62 X  
19-52-62  
19-52-62

A. C. V. D.

DIPOCOO DUEMONIA

JOHN O. STAFFORD 434 EZZA TERRACE

NO  
POLICE  
BALTO. CITY  
MD

M W X  
4-30-88 81  
SINAI HOSPITAL OF BALTO. 610 W. 36TH ST. #1  
BALTIMORE  
MARYLAND

STAFFORD, CLAUDE M.  
15-52-62  
p12

K-625

69 12885

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

69 12885

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) <b>CHARLES KERSHNER</b>		2. DATE OF DEATH Known <input type="checkbox"/> Estimated <input type="checkbox"/>		Month Day Year Hour	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>608 Homestead Street</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>December 25, 1969 12:05 A</b>		M.	
5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>905</b>		C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
6. SEX <b>Male</b>	7. RACE <b>White</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
9. DATE OF BIRTH <b>Jan. 15, 1916</b>		10. AGE (In years lost birthday) <b>53</b>		E. STREET AND NUMBER <b>608 Homestead Street</b>	
11. BIRTHPLACE (State or foreign country) <b>Frankford W. Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Estey Greigh Kirschner</b>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Emp. Martin Marietta Company</b>		14B. KIND OF BUSINESS OR INDUSTRY		15. MOTHER'S MAIDEN NAME <b>Susan Legg</b>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes WWII</b>		17. SOCIAL SECURITY NO. <b>234-12-5620</b>		18. INFORMANT <b>Jack K. Wallace Lewisberg W.VA.</b>	
19. <b>5-71-91</b>		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE <b>Cirrhosis of liver</b> DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) DUE TO, OR AS A CONSEQUENCE OF:			
(C) DUE TO, OR AS A CONSEQUENCE OF:					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>Chronic pancreatitis</b>					
20A. DATE OF OPERATION <b>2</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) <b>Yes</b>	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <b>Charles S. Springate, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>December 25, 1969</b>	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>			
		ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Removal</b>		24B. DATE <b>Dec. 28, 69</b>		24C. NAME OF CEMETERY or CREMATORY <b>Greenbrier Mem. Park</b>	
24D. LOCATION (City, town, or county) (State) <b>Lewisburg W. Va.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>DEC 30 1969</b>		25B. NAME OF REGISTRAR <b>Robert E. Jaber, M.D.</b>	
25C. FUNERAL DIRECTOR <b>Loring Byers</b>		25D. ADDRESS <b>8728 Liberty Rd. Randallstown</b>			



II

[illegible]



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="float: right;">69 12886</span>	
69 12886				CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>MR. HORACE H. SHRIEVES</b>		2. DATE AND HOUR OF DEATH <b>12/24/69 10 30 P.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <b>CERTIFICATE AMENDED</b> IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION <b>BON SECOURS HOSPITAL BALTIMORE, MD. 21223</b>			4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>2788</b>		
5. SEX <b>MALE</b> 6. RACE <b>WHITE</b> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			C. CITY OR TOWN		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>-</b>		11. BIRTHPLACE (State or foreign country) <b>VIRGINIA</b>
13. FATHER'S NAME <b>HORACE SHRIEVES</b>			14. MOTHER'S MAIDEN NAME <b>NETTIE Henry</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO *</b>		16. SOCIAL SECURITY NO. <b>219-05-1661</b>		17. INFORMANT ADDRESS <b>Mrs. Olive Shrieves 5424 Clover Rd. 21215</b>	
18. <b>1621 I</b> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>carcinoma of lungs</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (All stating the UNDERLYING CONDITION lost). <b>with metastasis to liver and active duodenal ulcer</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>0 -</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>-</b>		20A. AUTOPSY? (Yes or No) <b>-</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) <b>-</b>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <b>-</b>	
22. I certify that (I) (this hospital) attended the deceased from <b>11/15/69</b> to <b>12/24/69</b> and that (I) (we) last saw the deceased alive on <b>12/24/69</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Orathai Thirawat MD</b>				23B. DATE SIGNED <b>12/24/69</b>	
23C. PHYSICIAN'S NAME (Type) <b>ORATHAI THIRAWAT</b>		23D. ADDRESS <b>BON SECOURS HOSPITAL BALTO MD 23</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12/29/69</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cem.</b>	
24D. LOCATION (City, town, or county) (State) <b>Frederick Rd. Baltimore Md.</b>		25A. DATE REC'D BY HEALTH DEPT.			
25B. NAME OF REGISTRAR <b>Robert E. Fisher, M.D.</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Loring Byers 8728 Liberty Rd. Randallstown</b>			

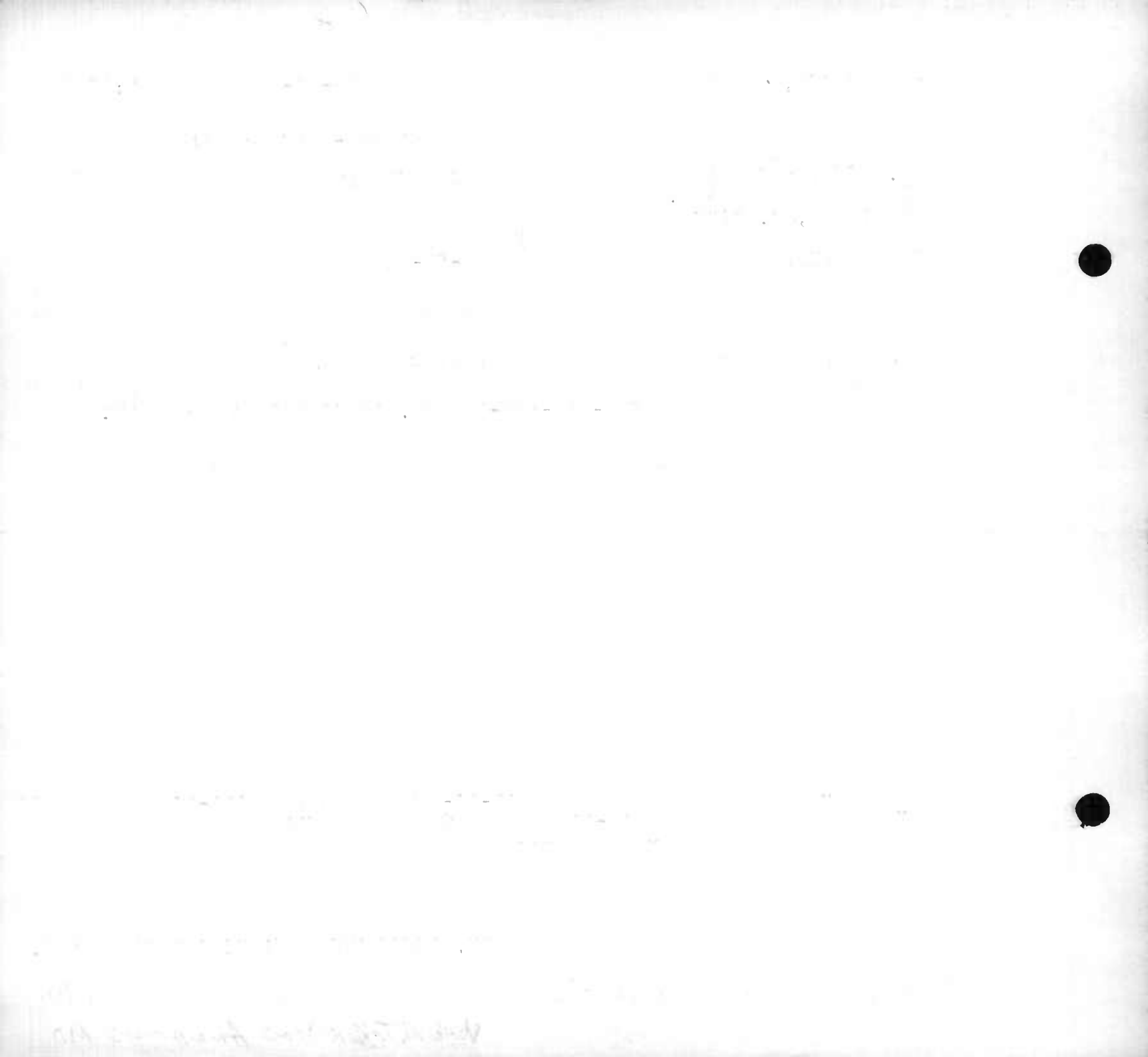
VS 153 1-13-76 M.H.

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

H-2001

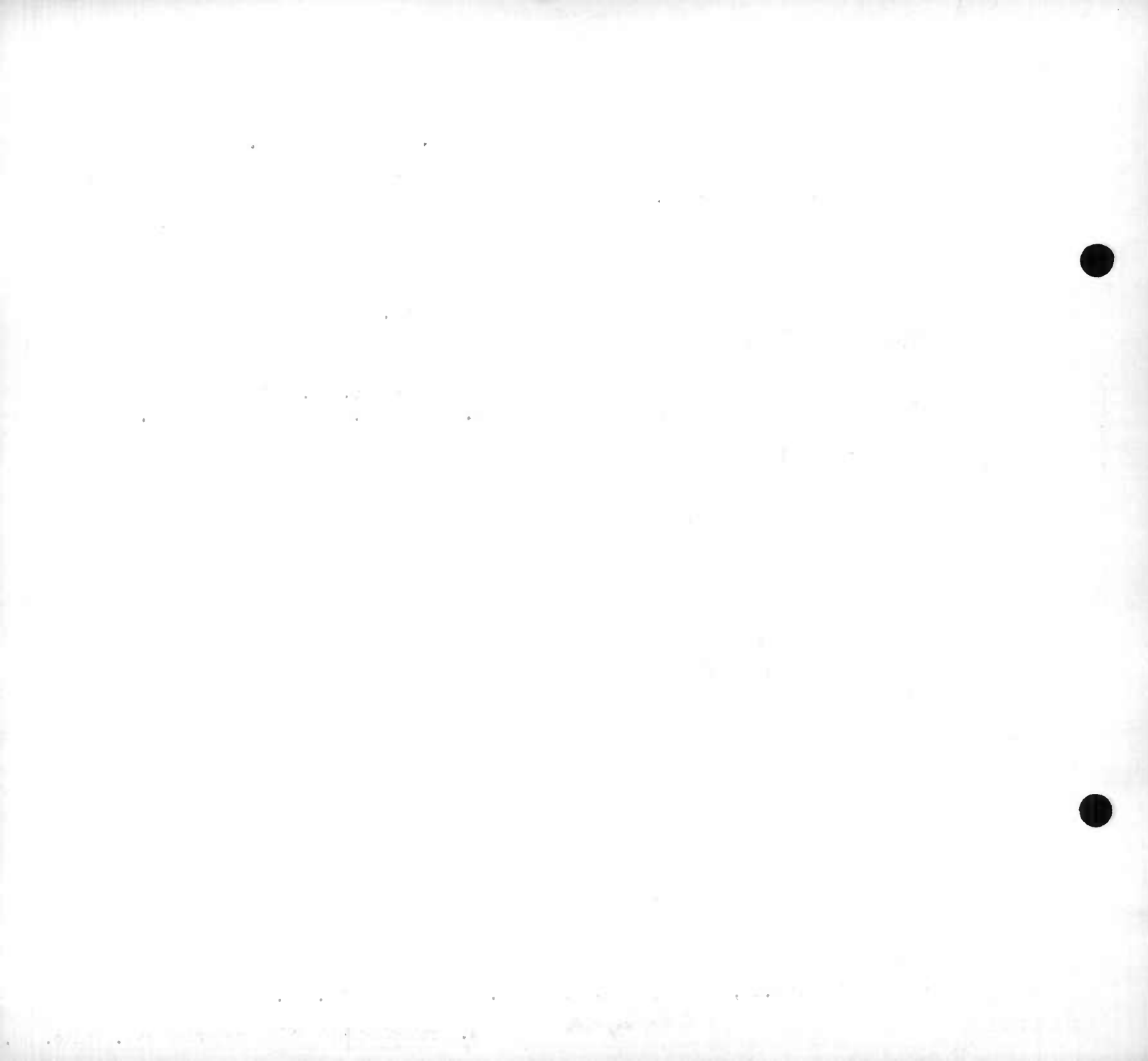
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 69 12887	
BIRTH NO. 69 12887		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) HIGGS, IVA		2. DATE AND HOUR OF DEATH 12-23-69 8:40 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) ST. AGNES HOSPITAL WILKENS & CATON AVE. BALTIMORE, MD. 21228		A. STATE MARYLAND - ANNA ARUNDEL 5200			
		C. CITY OR TOWN CROWNSVILLE		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
		E. STREET AND NUMBER			
5. SEX FEMALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 07-02-03	9. AGE (In years last birthday) 66	10. If Under 1 Yr. Months Days
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ?		10B. KIND OF BUSINESS OR INDUSTRY ?		11. BIRTHPLACE (State or foreign country) WASH. D.C.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Thompson Higgs			
14. MOTHER'S MAIDEN NAME KATHERINE F. ?		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) No			
16. SOCIAL SECURITY NO. 578-039-009-A		17. INFORMANT CATON ST. AGNES RECORD ROOM WILKENS &			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
I (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Pneumonia hydropneumothorax			
ANTECEDENT CAUSES		(B) DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) DUE TO, OR AS A CONSEQUENCE OF:			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (briefly medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (X) (this hospital) attended the deceased from 12-21-1969 to 12-23-1969 that (X) (we) lost saw the deceased alive on 12-23-1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.					
23A. SIGNATURE J. Muangsombut		23B. DATE SIGNED 12-23-69		23C. PHYSICIAN'S NAME (Type) J. MUANGSOMBUT MD	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 12-26-69		24C. NAME OF CEMETERY or CREMATORY CEDAR HILL	
24D. LOCATION Swithland P.G. MD.		25A. DATE REC'D BY HEALTH DEPT. DEC 30 1969		25B. NAME OF REGISTRAR Robert E. Taylor, MD.	
25C. FUNERAL DIRECTOR JOHN M. TAYLOR		25D. ADDRESS ANNAPOLIS MD			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		X	REG. NO.	69 12888
69 12888 <b>CERTIFICATE OF DEATH</b>				
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>Long, MARY ELIZABETH</u>		
2. DATE AND HOUR OF DEATH <u>12/26/1969</u> <u>2:10</u> A.M.				
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Church Home Hosp.</u>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>Balto.</u> C. CITY OR TOWN <u>Lansdowne</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER <u>343 THIRD AVE., BALTIMORE, MD.</u>		
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/1/1916</u>	9. AGE (in years last birthday) <u>53</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Balto.</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>HOLMES SMITH</u>		
14. MOTHER'S MAIDEN NAME <u>MARY KRAUSE</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service <u>no</u>		
16. SOCIAL SECURITY NO.		17. INFORMANT <u>Balto. Md. 21227</u> <u>Mr. Charles X. Long 343 Third Ave.</u>		
18. <u>410.91</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>Cardiac arrest.</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Possible myocardial infarct.</u>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				
19A. DATE OF OPERATION <u>6</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <u>12/25/1969</u> 19 to <u>12/26/1969</u> 19 that (I) (we) last saw the deceased alive on <u>12/25/1969</u> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <u>[Signature]</u>		23B. DATE SIGNED <u>12/26/69</u>		
23C. PHYSICIAN'S NAME (Type) <u>[Signature]</u>		23D. ADDRESS <u>[Signature]</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>Dec. 29, 1969</u>		24C. NAME OF CEMETERY OR CREMATORY <u>New Cathedral Cem.</u>
24D. LOCATION <u>Balto. Md.</u>				
25A. DATE REC'D BY HEALTH DEPT. <u>DEC 30 1969</u>		25B. NAME OF REGISTRAR <u>[Signature]</u>		25C. FUNERAL DIRECTOR <u>G. Truman Schwab</u>
25D. ADDRESS <u>3512 Frederick Ave. Balto. Md.</u>				



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

M-610		69 12889		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 69 12889	
<b>CERTIFICATE OF DEATH</b>							
1. NAME OF DECEASED (Type or Print) <i>Basil P. Murphy</i>				2. DATE AND HOUR OF DEATH <i>12/27/69 12<sup>30</sup> P.M.</i>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <i>Md.</i> B. COUNTY <i>2101</i>			
FULL NAME OF HOSPITAL OR INSTITUTION <i>00</i> <i>802 Woodward St.</i>				C. CITY OR TOWN <i>Baltimore</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <i>Male</i> 6. RACE <i>white</i>				7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>10/31/1905</i> 9. AGE (in years lost birthday) <i>64</i>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Conductor</i>				10B. KIND OF BUSINESS OR INDUSTRY <i>Balto. Transit Co.</i>		11. BIRTHPLACE (State or foreign country) <i>Baltimore Md.</i>	
13. FATHER'S NAME <i>Unknown</i>				14. MOTHER'S MAIDEN NAME <i>Unknown</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) <i>no</i> (If yes, give war or dates of service) <input checked="" type="checkbox"/>				16. SOCIAL SECURITY NO. <i>-</i>		17. INFORMANT <i>Mr. Gabriel S. Fischer</i> ADDRESS <i>8909 York Place Laurel Md. 20810</i>	
18. <i>412.21</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <i>Anterio-sclerotic and Hypertensive C.V.D.</i>				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Hypertensive C.V.D.</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>5 years</i>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO, OR AS A CONSEQUENCE OF: <i>-</i>		(C) <i>-</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <i>-</i>							
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>No</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <i>4-16 1965</i> to <i>12-27 1969</i> ; that (I) (we) last saw the deceased alive on <i>12-23 1969</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) ( <del>did</del> ) (did not) view the body after death.							
23A. SIGNATURE <i>Harry F. Kates M.D.</i>				Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <i>12-29-69.</i>	
23C. PHYSICIAN'S NAME (Type) <i>HARRY F. KATES MD</i>				23D. ADDRESS <i>517 Scott St - Balto, Md. 21230.</i>			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <i>12/30/69</i>		24C. NAME OF CEMETERY OR CREMATORY <i>New Cathedral Cem.</i>		24D. LOCATION (City, town, or county) (State) <i>Baltimore Md.</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>DEC 30 1969</i>		25B. NAME OF REGISTRAR <i>Robert E. Taylor, R.D.</i>		25C. FUNERAL DIRECTOR <i>John P. Brownson &amp; Co.</i>		ADDRESS <i>29 Collins St.</i>	





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

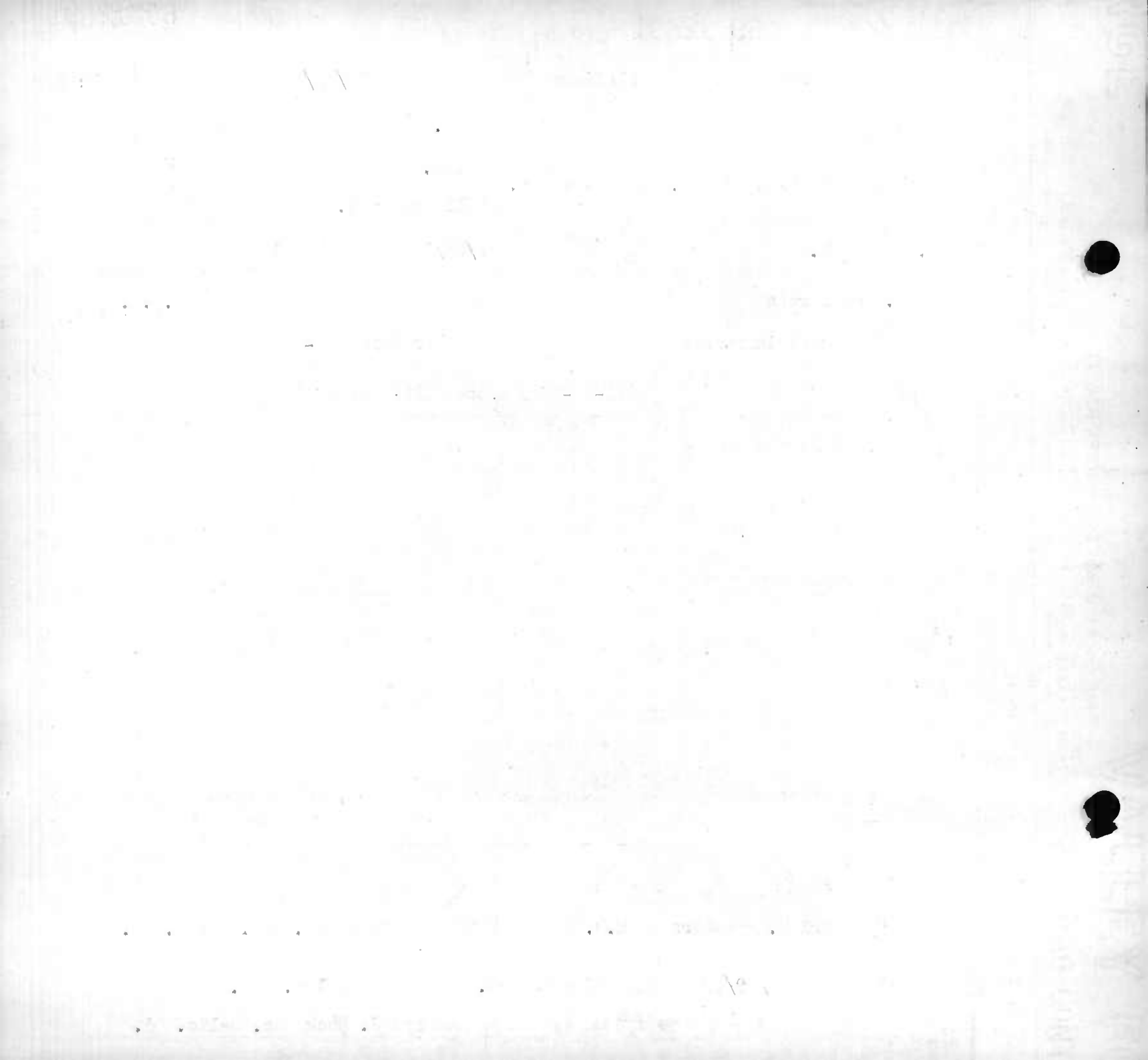
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <b>69 12880</b>	
S-450		69 12880		CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>TERRI C. SLOAN</b>		2. DATE AND HOUR OF DEATH <b>12-28-69 5:30 AM</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MARYLAND</b> 8. COUNTY <b>24-02</b>			
FULL NAME OF HOSPITAL OR INSTITUTION <b>JOHNS HOPKINS HOSPITAL BALTO., MD. 21205</b>		C. CITY OR TOWN <b>BALTIMORE</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		E. STREET AND NUMBER <b>1445 HENRY STREET</b>			
5. SEX <b>WHITE</b>	6. RACE <b>FEMALE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11-07-60</b>	9. AGE (In years last birthday) <b>9yr.</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Student</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>JOHN SLOAN</b>		14. MOTHER'S MAIDEN NAME <b>ROBERTA TINKER</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Mr John Sloan</b> ADDRESS <b>Same</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <b>3-9 0.01</b> (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>Student</b>		CAUSE OF DEATH <b>Cryptococcal Pleuritis</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Anemia</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 months</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF: <b>Chronic Renal failure</b>		<b>2 years</b>	
		(C) <b>Chronic Pyelonephritis</b>		<b>lifelong</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		<b>Anemia, azotemia</b>		<b>4 years</b>	
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>Dec 27 19 69</b> to <b>Dec 28 19 69</b> that (I) (we) lost saw the deceased alive on <b>Dec 27 19 69</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Russell W. Cheney MD</b>		23B. DATE SIGNED <b>12-28-69</b>		23C. PHYSICIAN'S NAME (Type) <b>Johns Hopkins Hospital</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12/31/69</b>		24C. NAME OF CEMETERY or CREMATORY <b>Gardens Of Faith</b>	
24D. LOCATION <b>Baltimore, Maryland</b>		25A. DATE REC'D BY HEALTH DEPT. <b>DEC 30 1969</b>		25B. NAME OF REGISTRAR <b>Robert E. Baker</b>	
25C. FUNERAL DIRECTOR <b>Donald J. Ruck Inc.</b>		25D. ADDRESS <b>Baltimore, Maryland</b>		25E. ADDRESS <b>Baltimore, Maryland</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

C-416		69 12891		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 69 12891	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) <b>Jennie Calafiore</b>			
2. DATE AND HOUR OF DEATH <b>12/24/69</b>				7:45 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Md.</b> B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>90 House in Pines 2525 W. Belvedere Ave.</b>				C. CITY OR TOWN <b>Balto.</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <b>5512 Todd Ave.</b>			
5. SEX <b>F.</b>	6. RACE <b>W.</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>2/25/1888</b>	9. AGE (In years last birthday) <b>81</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Ret. Seamstress</b>				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Italy</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				13. FATHER'S NAME <b>Vincent Ingrassia</b>			
14. MOTHER'S MAIDEN NAME <b>Virginia</b>				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>			
16. SOCIAL SECURITY NO. <b>214-14-3949</b>				17. INFORMANT <b>Rose Ellis same</b>			
18. CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>Broncho-pneumonia</b>				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>2 days</b>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) <b>51 Anterior Sclerotic Heart Disease</b> DUE TO, OR AS A CONSEQUENCE OF: <b>5 yrs</b>			
				(C) <b>Arterial Sclerosis</b> <b>2 yrs</b>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>Generalized Arterial Sclerosis</b>							
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>Dec. 19 - 1969</b> to <b>Dec. 24 - 1969</b> , that (I) <del>was</del> last saw the deceased alive on <b>Dec. 19 - 1969</b> and that in (my) <del>the</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>was</del> <del>did</del> (did not) view the body after death.							
23A. SIGNATURE <b>Earl C. Chambers M.D.</b>				23B. DATE SIGNED <b>12/27/69</b>		23C. PHYSICIAN'S NAME (Type) <b>Earl C. Chambers M.D.</b>	
23D. ADDRESS <b>4108 Liberty Heights Ave. Balto. Md.</b>							
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12/29/69</b>		24C. NAME OF CEMETERY or CREMATORY <b>Holy Redeemer Cem.</b>		24D. LOCATION (City, town, or county) (State) <b>Balto. Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 30 1969</b>		25B. NAME OF REGISTRAR <b>Robert E. Jackson</b>		25C. FUNERAL DIRECTOR <b>Leonard J. Buck Inc.</b>		ADDRESS <b>Balto. Md.</b>	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

D-225		69 12892		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		REG. NO. 69 12892	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) GRACE M. DEJACCHINO				2. DATE AND HOUR OF DEATH December 28, 1969 11.45 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY 901				5. CITY OR TOWN BALTIMORE			
FULL NAME OF HOSPITAL OR INSTITUTION 44 UNION MEMORIAL Hospital		IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
5. SEX Female		6. RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH 08-12-99		9. AGE (In years lost birthday) 70	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife Retired Beautician		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) ITALY		12. CITIZEN OF WHAT COUNTRY? NATIONALIZED AMERICAN			
13. FATHER'S NAME JOSEPH DEJACQUIN				14. MOTHER'S MAIDEN NAME VIRGINIA BLAZE Vincentua DeBlazio					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 220-07-5145		17. INFORMANT Miss Lucille DeJacquin				ADDRESS Same	
18. 4/10/91 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Myocardial infarction & pulmonary edema				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examined) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) APPROX.		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from December 26 19 69 to December 28 19 69 that (I) (we) lost saw the deceased alive on December 28 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE Miguel KARACUSCHANSKY, M.D.				23B. DATE SIGNED December 28, 1969		23C. PHYSICIAN'S NAME (Type) Miguel KARACUSCHANSKY, M.D.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/31/69		24C. NAME OF CEMETERY or CREMATORY Lorraine Park		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland			
25A. DATE REC'D BY HEALTH DEPT. DEC 30 1969		25B. NAME OF REGISTRAR Robert E. Jaber, M.D.		25C. FUNERAL DIRECTOR Leonard J. Buck Inc.		ADDRESS Baltimore, Maryland			

Union Memorial Hospital

612 PARKWAY AVENUE

PP-11-80 X 50

HOUSEWIFE

ITALY

JOSEPH DELACROIX

VIRGINIA BLADE

WASHINGTON  
AREA FOR

Miguel KARRACHANSKY M.D.

Union Memorial Hospital

Miguel KARRACHANSKY M.D.

December 28 1980

69

December 22

X

December 22 1981

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-624 69 12893		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 69 12893	
1. NAME OF DECEASED (Type or Print) <b>BROCCOLINA, SEBASTIAN</b> (Sebastiana)		2. DATE AND HOUR OF DEATH <b>12-29-69 1:15 A.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>37 MERCY HOSPITAL</b>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>302</b> C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>230 Albemarle St.</b>			
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7-25-78</b>	9. AGE (in years last birthday) <b>91</b>	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Foreman</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Balto. Transit Co.</b>		11. BIRTHPLACE (State or foreign country) <b>Italy</b>	
12. CITIZEN OF WHAT COUNTRY? <b>Italy</b>		13. FATHER'S NAME <b>Louis Broccolina</b>		14. MOTHER'S MAIDEN NAME <b>Rachel ?</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>213-05-9356</b>		17. INFORMANT <b>Mrs. Josephine Broccolina</b> ADDRESS (Same)	
18. <b>410.9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>Cardiac shock</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Myocardial Infarction, probable</b> <b>Constrictive Heart Failure</b> <b>Septic ulcer &amp; GI bleeding</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
MEDICAL CERTIFICATION					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>12/28</b> 19 <b>69</b> to <b>12/29</b> 19 <b>69</b> that (I) (we) last saw the deceased alive on <b>12/29</b> 19 <b>69</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Manuela M. Ribeiro, M.D.</b>		23B. DATE SIGNED <b>12/29/69</b>		23C. PHYSICIAN'S NAME (Typal) <b>MANUELA M. RIBEIRO, M.D.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1/2/70.</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Holy Redeemer Cemetery</b>	
24D. LOCATION <b>Baltimore, Md.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>DEC 30 1969</b>		25B. NAME OF REGISTRAR <b>Robert E. Salsbery, M.D.</b>	
25C. FUNERAL DIRECTOR <b>Georg J. Duck, Inc.</b>		25D. ADDRESS <b>Balto. Md. 21214</b>			

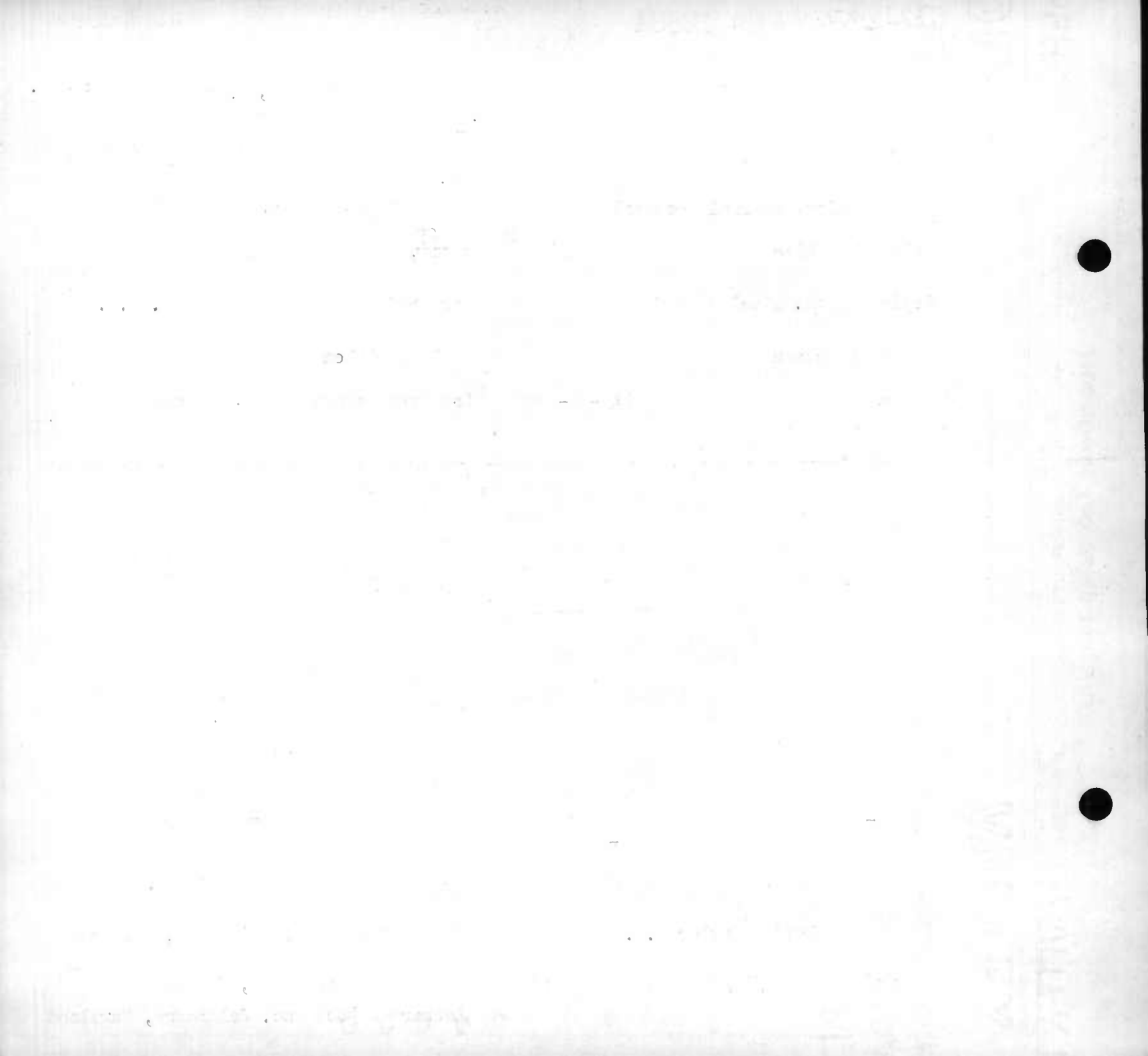
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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

M-250 69 12894				BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 69 12894	
1. NAME OF DECEASED (Type or Print) <b>John J Mc Cann</b>				2. DATE AND HOUR OF DEATH <b>December 28, 1969 9:30 A.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  <b>44 Union Memorial Hospital</b>				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>2748</b>			
FULL NAME OF HOSPITAL OR INSTITUTION <b>44 Union Memorial Hospital</b>				C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <b>5705 Chinquapin Parkway</b>							
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Aug 22, 1897</b>		9. AGE (In years last birthday) <b>72</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Beth. Steel</b>				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>							
13. FATHER'S NAME <b>John McCann</b>				14. MOTHER'S MAIDEN NAME <b>Ellen Dillon</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>215-14-7899</b>		17. INFORMANT <b>Miss Mary McCann</b>	
				ADDRESS <b>Same</b>			
18. <b>412.4 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Arteriosclerotic cardiovascular disease</b> (B) DUE TO, OR AS A CONSEQUENCE OF: (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>10 yrs.</b>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>April 21, 1969</b> to <b>December 28, 1969</b> , that (I) (we) last saw the deceased alive on <b>November 17, 1969</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>Lloyd E Saylor</i> DEGREE				Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <b>Dec. 29, 1969</b>	
23C. PHYSICIAN'S NAME (Type) <b>Lloyd E Saylor M.D.</b> DEGREE				23D. ADDRESS <b>3902 Greenmount Ave Baltimore, Maryland</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12/31/69</b>		24C. NAME OF CEMETERY or CREMATORY <b>New Cathedral</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 30 1969</b>		25B. NAME OF REGISTRAR <b>Leonard J Buck Inc.</b>		25C. FUNERAL DIRECTOR <b>Leonard J Buck Inc.</b>		ADDRESS <b>Baltimore, Maryland</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <b>69 12895</b>	
S-432 69 12895		CERTIFICATE OF DEATH	
BIRTH NO.		2. DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print) <b>Carl George Scholtz</b>		<b>12/25/69</b> <span style="float: right;"><b>322 P M.</b></span>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>1900 Ramblewood Road Apt. D.</b>		A. STATE <b>Md.</b> B. COUNTY <b>2758</b>	
5. SEX <b>M.</b>		6. RACE <b>W.</b>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>8/21/1897</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Electric Union</b>		9. AGE (In years last birthday) <b>72</b>	
10B. KIND OF BUSINESS OR INDUSTRY <b>Business Mgr.</b>		11. BIRTHPLACE (State or foreign country) <b>Md.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Irvin Scholtz</b>	
14. MOTHER'S MAIDEN NAME <b>Christine Jordon</b>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>yes WWI</b>	
16. SOCIAL SECURITY NUMBER <b>215-01-7866</b>		17. INFORMANT ADDRESS <b>Irene Scholtz same</b>	
18. <b>342X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Robinson's Disease</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>8 yrs</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Nat While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>January 19 62</b> to <b>December 15 1969</b> , that (I) (we) lost saw the deceased alive on <b>December 15 1969</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <b>A. Allen Spier M.D.</b>		23B. DATE SIGNED <b>12/27/69</b>	
23C. PHYSICIAN'S NAME (Type) <b>Allen Spier M.D.</b>		23D. ADDRESS <b>1501 Pentridge Rd. Balto. Md.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12/29/69</b>	
24C. NAME of CEMETERY or CREMATORY <b>Moreland Mem. Park</b>		24D. LOCATION (City, town, or county) (State) <b>Balto. Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 30 1969</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>	
25C. FUNERAL DIRECTOR <b>Leonard S. Ruck Inc.</b>		ADDRESS <b>Balto. Md.</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

A-416		69 12896		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 69 12896	
BIRTH NO.				1. NAME OF DECEASED (Type or Print)			
				Joseph Charles Albert Jr.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  00 3310 Northway Drive				A. STATE Maryland		B. COUNTY 2745	
				C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER 3047 Fleetwood Avenue				8. DATE OF BIRTH April 20, 1902		9. AGE (In years last birthday) 67	
5. SEX Male		6. RACE Caucasian		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Pari-Mutuel Clerk	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Hungary		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Joseph C. Albert Sr.				14. MOTHER'S MAIDEN NAME Adel Sartorius			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 220-05-7171		17. INFORMANT Mrs Naomi M Albert 3047 Fleetwood Ave 21214			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  410.9 I CAUSE OF DEATH M-I. A.S.H.D.				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 60 12896			
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (the physician) attended the deceased from 19 to 19, that (I) (we) last saw the deceased alive on 19 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
23A. SIGNATURE  M.D. DEGREE				23B. DATE SIGNED December 27, 1969		23C. PHYSICIAN'S NAME (Type) Fernando Juliao	
23D. ADDRESS 5428 1/2 Sinclair Lane Baltimore Maryland		24A. BURIAL CREMATION, REMOVAL (Specify) Burial					
24B. DATE 12-30-69		24C. NAME of CEMETERY or CREMATORY Gardens of Faith		24D. LOCATION (City, town, or county) (State) Balto. Md.			
25A. DATE REC'D BY HEALTH DEPT. DEC 30 1969		25B. NAME OF REGISTRAR Robert E. Fisher		25C. FUNERAL DIRECTOR Leonard O. Rock Inc. 5305 Harford Rd. 21214			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. 69 12897
BIRTH NO. <u>K-414</u>		69 12897		
1. NAME OF DECEASED (Type or Print) <u>Mary K. Kalbfleisch</u>		2. DATE AND HOUR OF DEATH <u>Dec-28, 69 10:10 A.M.</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <u>North Charles Gen. Hosp.</u> <u>49 Baltimore, Md</u>		A. STATE <u>Md.</u> B. COUNTY <u>Baltimore</u> <u>5300</u>		
IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION		C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
5. SEX <u>F</u>		6. RACE <u>N W</u>		E. STREET AND NUMBER <u>2 Fellowship Ct. Apt. #1</u>
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3/29/84</u>		9. AGE (In years last birthday) <u>85</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>		13. FATHER'S NAME <u>Henry Robert</u>		
14. MOTHER'S MAIDEN NAME <u>Mary Tavis</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>—</u>		
16. SOCIAL SECURITY NO. <u>215-09-3491</u>		17. INFORMANT <u>Trop. Record</u> ADDRESS <u>—</u>		
18. <u>250.91</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH <u>Arteriosclerotic cardiovascular disease</u> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Diabetes mellitus</u> (B) DUE TO, OR AS A CONSEQUENCE OF: <u>Urinary tract infection</u> (C) <u>—</u>		
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>—</u>		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>II</u>		
19A. DATE OF OPERATION <u>—</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>—</u>		20A. AUTOPSY? (Yes or No) <u>No</u>
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>—</u>		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>—</u>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>—</u>		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <u>—</u>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <u>—</u>
22. I certify that (I) (this hospital) attended the deceased from <u>Dec. 27</u> 19 <u>69</u> to <u>Dec-28</u> 19 <u>69</u> that (I) (we) last saw the deceased alive on <u>Dec-28</u> 19 <u>69</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <u>V. Chitrapiec</u>		23B. DATE SIGNED <u>Dec-28, 69</u>		23C. PHYSICIAN'S NAME (Type) <u>V. Chitrapiec</u>
23D. ADDRESS <u>North Charles Gen. Hosp.</u>		23E. DEGREE <u>—</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>12/30/69</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Moreland Memorial Park</u>
24D. LOCATION (City, town, or county) <u>Baltimore, Maryland</u>		24E. STATE <u>Md.</u>		
25A. DATE REC'D BY HEALTH DEPT. <u>DEC 30 1969</u>		25B. NAME OF REGISTRAR <u>Robert E. Naber, Jr.</u>		25C. FUNERAL DIRECTOR <u>Leonard J. Ruck Inc.</u>
25D. ADDRESS <u>Baltimore, Maryland</u>		25E. <u>—</u>		





**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<p><b>P-620</b></p> <p><b>69 12898</b></p>		<p><b>BALTIMORE CITY HEALTH DEPARTMENT</b></p> <p><b>CERTIFICATE OF DEATH</b></p>		<p>REG. NO. <b>69 12898</b></p>	
<p><b>BIRTH NO.</b></p>		<p><b>1. NAME OF DECEASED</b> (Type or Print) <b>CARVEL PIERCE</b></p>		<p><b>2. DATE AND HOUR OF DEATH</b> <b>12-28-69 10.00 A.M.</b></p>	
<p><b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b></p> <p>FULL NAME OF HOSPITAL OR INSTITUTION <b>37 MERCY HOSPITAL</b></p> <p>(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)</p>		<p><b>4. USUAL RESIDENCE</b> (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>903</b></p> <p>C. CITY OR TOWN <b>Balto.</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></p> <p>E. STREET AND NUMBER <b>3714 Monterey Rd.</b></p>			
<p><b>5. SEX</b> <b>M</b></p>	<p><b>6. RACE</b> <b>W</b></p>	<p><b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/></p>	<p><b>8. DATE OF BIRTH</b> <b>11-15-75</b></p>	<p><b>9. AGE</b> (in years last birthday) <b>94</b></p>	<p><b>10. UNDER 1 Yr. Months Days</b> <b>11. UNDER 24 Hrs. Hours Min.</b></p>
<p><b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Retired Horse Trainer</b></p>		<p><b>10B. KIND OF BUSINESS OR INDUSTRY</b></p>		<p><b>11. BIRTHPLACE</b> (State or foreign county) <b>Maryland</b></p>	
<p><b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b></p>		<p><b>13. FATHER'S NAME</b> <b>Jacob G. Pierce</b></p>			
<p><b>14. MOTHER'S MAIDEN NAME</b> <b>Sarah Ann Turpbaugh</b></p>		<p><b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) <b>No</b></p>			
<p><b>16. SOCIAL SECURITY NO.</b> <b>218-18-0691</b></p>		<p><b>17. INFORMANT</b> <b>Mr Henry Pierce</b> ADDRESS <b>Same</b></p>			
<p><b>18. CAUSE OF DEATH</b></p> <p><b>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</p> <p><b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p> <p><b>(A) IMMEDIATE CAUSE</b> <b>Cardiac failure</b> DUE TO, OR AS A CONSEQUENCE OF:</p> <p><b>(B) ASCVD CHF.</b> DUE TO, OR AS A CONSEQUENCE OF:</p> <p><b>(C) COLD.</b></p> <p><b>II</b> <b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).</b> <b>Intestinal obstruction</b></p> <p><b>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</b></p>					
<p><b>19A. DATE OF OPERATION</b> <b>3/15 + 12/19</b></p>		<p><b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b> <b>lacerated laceration</b></p>		<p><b>20A. AUTOPSY? (Yes or No)</b> <b>Yes</b></p>	
<p><b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (Notify medical examiner)</p>		<p><b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>		<p><b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)</p>	
<p><b>21D. TIME OF INJURY (APPROX.)</b> (Month) (Day) (Year) (Hour)</p>		<p><b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>		<p><b>21F. HOW DID INJURY OCCUR?</b></p>	
<p><b>22. I certify that (it) (this hospital) attended the deceased from <u>12/6/69</u> 19 to <u>12/28/69</u> 19</b> <b>that (I) (we) last saw the deceased alive on <u>12/28/69</u> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</b></p>					
<p><b>23A. SIGNATURE</b> <b>Dr. W. E. King MD</b></p>		<p><b>23B. DATE SIGNED</b> <b>12/28/69</b></p>		<p><b>23C. PHYSICIAN'S NAME (Type)</b></p>	
<p><b>23D. ADDRESS</b></p>		<p><b>23E. ADDRESS</b></p>			
<p><b>24A. BURIAL CREMATION, REMOVAL (Specify)</b> <b>Burial</b></p>		<p><b>24B. DATE</b> <b>12/31/69</b></p>		<p><b>24C. NAME OF CEMETERY OR CREMATORY</b> <b>Holy Redeemer</b></p>	
<p><b>24D. LOCATION</b> (City, town, or county) (State) <b>Baltimore, Maryland</b></p>		<p><b>25A. DATE REC'D BY HEALTH DEPT.</b> <b>DEC 30 1969</b></p>			
<p><b>25B. NAME OF REGISTRAR</b> <b>Robert E. Taylor, R.D.</b></p>		<p><b>25C. FUNERAL DIRECTOR</b> <b>Leonard J. Ruck Inc. Baltimore, Maryland</b></p>			



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69 12899 BALTIMORE CITY HEALTH DEPARTMENT

**R-240**

**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

BIRTH NO. **69 12899** REG. NO. **69 12899**

1. NAME OF DECEASED (Type or Print)		2. DATE OF DEATH		3. DATE PRONOUNCED DEAD		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)	
GREGORY RUSSELL <i>M.</i>		Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year December 25, 1969		Month Day Year December 25, 1969		Hour 12:15 A.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		7. RACE		B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN	
33 Johns Hopkins Hospital		Male		Negro		Baltimore	
9. DATE OF BIRTH		10. AGE (In years last birthday)		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
March 31-57		19		Baltimore Md		U.S.A.	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY		13. FATHER'S NAME		15. MOTHER'S MAIDEN NAME	
Student				Charles Russell		Lula Mae	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.		18. INFORMANT		ADDRESS	
No				Charles Russell		Same	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
E9651		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		Gunshot wound of chest			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) DUE TO, OR AS A CONSEQUENCE OF:					
(C) DUE TO, OR AS A CONSEQUENCE OF:							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No)			
2				Yes			
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
		Home		1127 Wilmont Court		1002	
22D. TIME OF INJURY (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR?			
12-24-69 11:30 P.m.				Shot at home			
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE		Charles S. Springate, M.D.		CHIEF MEDICAL EXAMINER		DATE SIGNED	
EXAMINER'S NAME (Type)		Charles S. Springate, M.D.		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		December 25, 1969	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		12-30-69		Mt Lebanon Cent		Baltimore Md	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
DEC 30 1969		R. E. Taylor, Jr.		Clayton Wilson		1000 Crumley Rd	

VS 151-REV. 1/1/68

ACAPBEXX 010MID

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<div style="display: flex; justify-content: space-between;"> <span>G-520</span> <span>69 12900</span> <span>BALTIMORE CITY HEALTH DEPARTMENT</span> </div> <h2 style="text-align: center;">CERTIFICATE OF DEATH</h2> <div style="display: flex; justify-content: space-between;"> <span>BIRTH NO.</span> <span>REG. NO.</span> </div>			
1. NAME OF DECEASED (Type or Print) <u>LOUISE GOMEZ</u>		2. DATE AND HOUR OF DEATH <u>12/24/69</u> <u>11:30</u> <u>A.</u> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION <u>31</u> (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Baltimore City Hospital</u> <u>4940 Eastern Avenue</u> <u>Baltimore, Maryland 21224</u>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>604</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>406 Chapel St., Balto., Md. 21231</u>	
5. SEX <u>Female</u>	6. RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-7-1898</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <u>81</u> If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY <u>United States</u>	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME <u>Royal</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>BCH Records:</u>		ADDRESS <u>4940 Eastern Avenue</u> <u>Baltimore, Md. 21224</u>	
18. <u>410.91</u> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			
(A) IMMEDIATE CAUSE <u>MYOCARDIAL INFARCTION</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 HRS.</u>	
(B) <u>A.S.C.V.D.</u>		<u>YEARS</u>	
(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>CHRONIC URINARY TR. INF.</u> <u>YEARS</u>			
19A. DATE OF OPERATION <u>0</u>	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) <u>NO</u>	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I certify that <u>HY</u> (this hospital) attended the deceased from <u>11/6</u> 19 <u>67</u> to <u>12/24</u> 19 <u>69</u> that <u>HY</u> (we) last saw the deceased alive on <u>12/24</u> 19 <u>69</u> and that in (my) <u>last</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>(WE)</u> (did) (did not) view the body after death.			
23A. SIGNATURE <u>Dennis Bleakley MD</u>		23B. DATE SIGNED <u>12/24/69</u>	
23C. PHYSICIAN'S NAME (Type) <u>Dennis Bleakley, M.D.</u>		23D. ADDRESS <u>Baltimore City Hospital</u> <u>4940 Eastern Avenue</u> <u>Baltimore, Maryland 21224</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>	24B. DATE <u>12/27/69</u>	24C. NAME OF CEMETERY OR CREMATORY <u>ARBUTUS MEM PK.</u>	24D. LOCATION <u>ARBUTUS MD.</u>
25A. DATE REC'D BY HEALTH DEPT. <u>DEC 30 1969</u>		25B. NAME OF REGISTRAR <u>Ed Wilson</u>	
25C. FUNERAL DIRECTOR		ADDRESS <u>1000 BRANTLEY AVE</u>	



M-325

69 12901 BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 69 12901

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>WILLIAM M. MITCHNER</b>		2. DATE OF DEATH Known <input type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour <b>December 10, 1969 10:25 A.M.</b>	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>828 N. Dallas Street (DOA)</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>December 10, 1969 10:25 A.M.</b>	
5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>704</b>		6. SEX <b>Male</b> 7. RACE <b>Negro</b> 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH <b>5-26-1915</b>		10. AGE (In years lost birthday) <b>50</b> 11. BIRTHPLACE (State or foreign country) <b>Goldensville, N.C.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Alexander Mitchner</b>	
14. AA. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b> 14B. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>		15. MOTHER'S MAIDEN NAME <b>Martha Hooks</b>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		17. SOCIAL SECURITY NO.	
18. INFORMANT <b>M</b>		ADDRESS	
19. CAUSE OF DEATH <b>412.41</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Arteriosclerotic Cardiovascular Disease</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
20A. DATE OF OPERATION <b>2</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Ronald N. Kornblum</b> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Ronald N. Kornblum, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12-19-69</b>	
24C. NAME OF CEMETERY or CREMATORY <b>McGowan Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Alameda County, Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 30 1969</b>		25B. NAME OF REGISTRAR <b>Robert E. Wilson</b>	
		25C. FUNERAL DIRECTOR <b>Robert E. Wilson</b>	
		ADDRESS <b>1001 Brumby</b>	



ACADEMIC RECORD



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

C-450 69 12902		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 69 12902
<b>CERTIFICATE OF DEATH</b>				
1. NAME OF DECEASED (Type or Print) <u>Grace Calhoun</u>		2. DATE AND HOUR OF DEATH <u>12/17/69</u> <u>10<sup>20</sup></u> P.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MD</u> B. COUNTY <u>23</u>		
FULL NAME OF HOSPITAL OR INSTITUTION <u>Century Home</u> <u>10102 W. Poca St.</u>		C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
E. STREET AND NUMBER <u>1604</u>				
5. SEX <u>F</u>	6. RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/17/06</u>	9. AGE (In years lost birthday) <u>63</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTH PLACE (State or foreign country) <u>SUFFOLK Va.</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				
13. FATHER'S NAME <u>GEORGE COLEY</u>		14. MOTHER'S MAIDEN NAME <u>ETTA ROGERS</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>23-26-0700</u>		17. INFORMANT <u>LUCINDA MANNING</u>
ADDRESS <u>S/A</u>				
18. <u>250.9 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.		CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>Cardio Respiratory Failure</u> DUE TO, OR AS A CONSEQUENCE OF: <u>Massive Cerebral Hemorrhage</u> (B) <u>Gen &amp; Cerebral Arteriosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>Diabetes mellitus</u>		
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <u>Oct 16</u> 19 <u>69</u> to <u>Dec 17</u> 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>Dec 17</u> 19 <u>69</u> and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>we</del> ) ( <del>did not</del> ) view the body after death.				
23A. SIGNATURE <u>William D Appleford</u>		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED
23C. PHYSICIAN'S NAME (Type) <u>William D Appleford</u>		23D. ADDRESS <u>6615 Reisterstown Rd</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>12/29/69</u>		24C. NAME OF CEMETERY OR CREMATORY <u>MT AUBURN</u>
24D. LOCATION (City, town, or county) (State) <u>BALTO. MD.</u>				
25A. DATE REC'D BY HEALTH DEPT. <u>DEC 30 1969</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor</u>		25C. FUNERAL DIRECTOR <u>E. J. O'Sullivan</u>
ADDRESS <u>2191</u>				

1900

Charles H. Hays  
President of the  
Board of Directors  
of the  
Hays Building

Dec 17 1900

✓  
Received of the  
Hays Building

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>69 12903</u>	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
<u>Ray Matthews</u>		<u>Dec., 17, 1969 8:45 P.M.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION  <u>90 1105 E. Fayette Street</u>		A. STATE <u>Maryland</u>		B. COUNTY <u>806</u>	
		C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER <u>1603 N. Broadway</u>			
5. SEX <u>F</u>	6. RACE <u>N</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-1-1880</u>	9. AGE (in years last birthday) <u>89</u>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country)	
13. FATHER'S NAME <u>Tige</u>		14. MOTHER'S MAIDEN NAME <u>Mary Bell</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>222 12 7193A</u>		17. INFORMANT <u>Hazel Matthews</u> ADDRESS <u>1050 N. Broadway</u>	
18. CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>CHF</u>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 wk</u>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (b) <u>RSVD</u> (c) <u>Stabitus Mellitus</u>				DUE TO, OR AS A CONSEQUENCE OF: <u>Stabitus Mellitus</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>Cataract anuria old CRA.</u>					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) <del>(this hospital)</del> attended the deceased from <u>Nov., 6, 1969</u> to <u>Nov., 17, 1969</u> and that (I) <del>(we)</del> last saw the deceased alive on <u>Nov., 17, 1969</u> and that in (my) <del>(our)</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>(We)</del> (did) <del>(did not)</del> view the body after death.					
23A. SIGNATURE <u>Isador Shiller</u>		23B. DATE SIGNED <u>17 Dec 69</u>		23C. PHYSICIAN'S NAME (Type) <u>Isador Shiller</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>12-23-69</u>		24C. NAME OF CEMETERY or CREMATORY <u>MT. Auburn C.</u>	
24D. LOCATION (City, town, or county) (State) <u>Baltimore Md</u>		24E. FUNERAL DIRECTOR <u>Robt E. Taylor, Jr.</u>		24F. ADDRESS <u>2214 E Fayette St</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>DEC 30 1969</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, Jr.</u>		25C. FUNERAL DIRECTOR <u>Robt E. Taylor, Jr.</u>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.	69 12904
M-300		69 12904		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <b>MELINDA MARY MAITH</b>		2. DATE AND HOUR OF DEATH <b>12-20-69 7:16 a.m.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  <b>FRANKLIN SQUARE HOSPITAL</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> - B. COUNTY <b>BALTIMORE</b> C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>7401 LINDEN AVENUE P.</b>			
5. SEX <b>F</b>	6. RACE <b>N</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6-1-1900</b>	9. AGE (In years last birthday) <b>69</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>NORTHUMBERLAND Co.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>JOHN LAWSON</b>		14. MOTHER'S MAIDEN NAME <b>SAUNA</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>JOHN MAITH SR</b>	
18. <b>402X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE <b>CARDIAC ARREST</b> DUE TO, OR AS A CONSEQUENCE OF: (B) <b>HYPERTENSIVE DISEASE</b> DUE TO, OR AS A CONSEQUENCE OF: (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>12-15-69</b> 19 to <b>12-20-69</b> 19, that (I) (we) last saw the deceased alive on <b>Dec. 20</b> 19 <b>69</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>H. Davalos M.D.</b>		23B. DATE SIGNED <b>12-20-69</b>		23C. PHYSICIAN'S NAME (Type) <b>Dr Hugo DAVALOS</b>	
23D. ADDRESS <b>BALTIMORE, MARYLAND</b>		23E. ADDRESS <b>9000 FRANKLIN SQUARE DRIVE</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>	24B. DATE <b>12/23/69</b>	24C. NAME OF CEMETERY or CREMATORY <b>CARVER MEM PARK</b>		24D. LOCATION (City, town, or county) (State) <b>LAUREL, MD.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 30 1969</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR <b>E. J. Wilson</b>	
25D. ADDRESS		25E. ADDRESS			

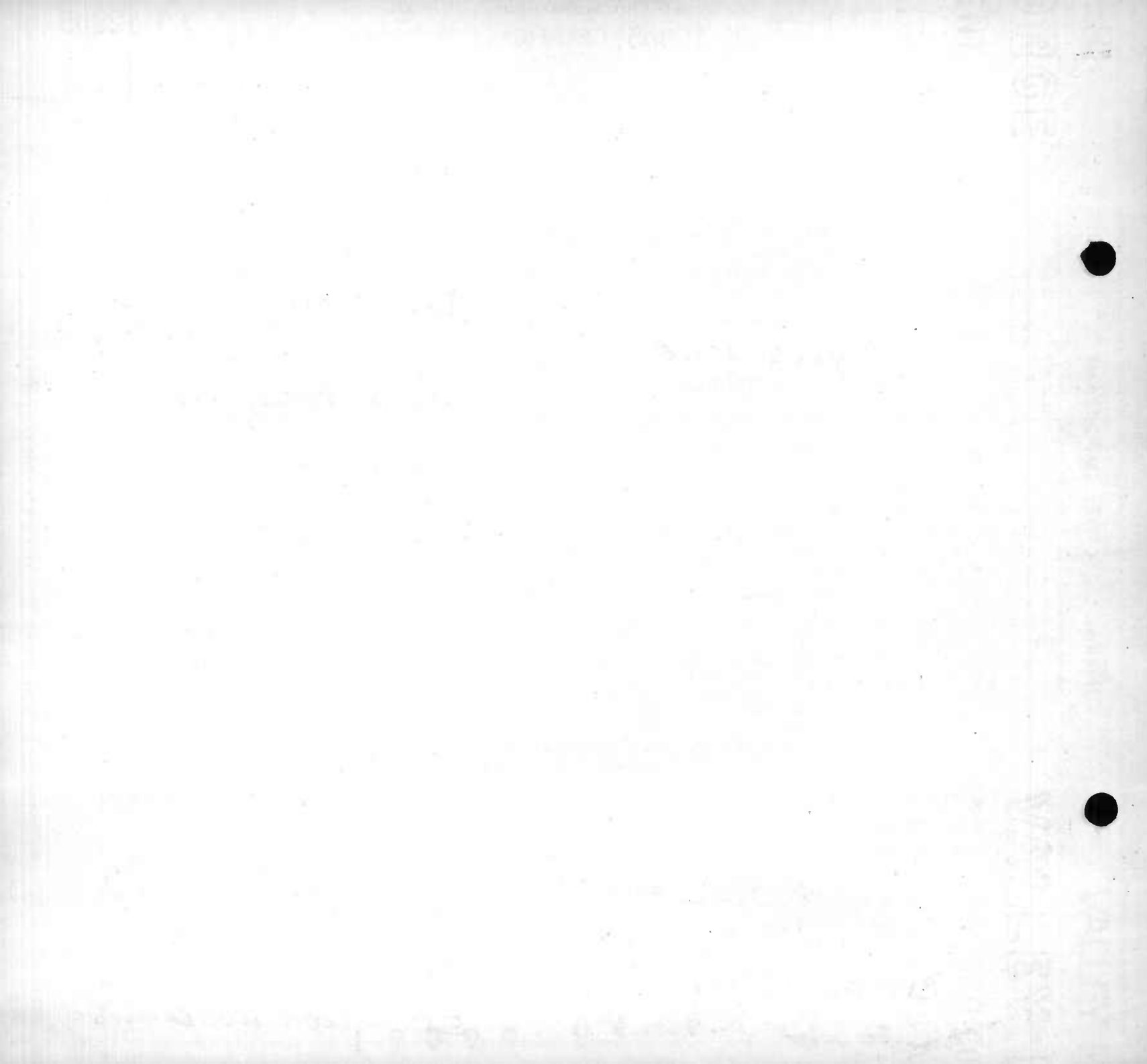
6-1-1900

BURIAL 10/2/11 (under New York Avenue, N.Y.C.)

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

J-520		69 12905		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 69 12905	
BIRTH NO.				2. DATE AND HOUR OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>Jones, Harry T</b>				21 December 1969 11:45 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>Johns Hopkins Hospital</b>				A. STATE <b>Maryland</b>		B. COUNTY <b>Balt</b>	
				C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <b>2002 E. Biddle Street</b>			
5. SEX <b>male</b>	6. RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>4/30/92</b>	9. AGE (In years last birthday) <b>74</b>	If Under 1 Yr. Months: Days: Hours: Min.	If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>BALTO MD.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>SYRUS JONES</b>				14. MOTHER'S MAIDEN NAME <b>Mary Elizabeth Jones (NEEDSHIELDS)</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>ANNA MOSLEY</b>		ADDRESS <b>1022 ASHLAND CT.</b>	
18. <b>185X1</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.				CAUSE OF DEATH (A) IMMEDIATE CAUSE <b>Cachexia</b> DUE TO, OR AS A CONSEQUENCE OF:  (B) <b>Widespread metastasis of</b> <b>Carcinoma of the Prostate</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>&gt; 3 mo.</b>  <b>&gt; 3 mo.</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <b>19 Dec 69</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Orchidectomy for Carcinoma</b>		20A. AUTOPSY? (Yes or No) <b>Yes</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>15 December 19 69</b> to <b>21 December 19 69</b> , that (I) (we) last saw the deceased alive on <b>21 December 19 69</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>James D. Biles, M.D.</b>				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>21 December 1969</b>	
23C. PHYSICIAN'S NAME (Type) <b>James D. Biles, M.D.</b>		23D. ADDRESS <b>Johns Hopkins Hospital.</b>					
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>	24B. DATE <b>12/26/69</b>	24C. NAME OF CEMETERY or CREMATORY <b>BALTO NATL CEM</b>		24D. LOCATION (City, town, or county) (State) <b>BALTO. MD.</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 30 1969</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR <b>E.O. WILSON</b>		ADDRESS <b>1000 BRANTLEY AVE</b>	





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 69 12906	
D-542		69 12906		CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		DANIELS, BLANCHE		December 26th, 1969 8:30 P. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			A. STATE B. COUNTY		
UNION MEMORIAL HOSPITAL			C. CITY OR TOWN		D. INSIDE CITY LIMITS?
			BALTIMORE		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER		
			2767 THE ALAMEDA		
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
FEMALE	NEGRO	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	6/10/09	60	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
RETIRED				SOUTH CAROLINA	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
JAMES BETHEA		CARRIE TOWSON		U. S. A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No				JAMIE COLE SAME AS ABOVE	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)			CAUSE OF DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
				No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from December 26th 1969 to December 26th 1969, that (I) (we) last saw the deceased alive on December 26th 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE			23B. DATE SIGNED		
J. Cabrera M.D.			December 27th 1969		
23C. PHYSICIAN'S NAME (Type)			23D. ADDRESS		
JUAN CABRERA V. M.D.			UNION MEMORIAL HOSPITAL		
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
Burial		2 Jan 70		Bethel G.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
DEC 30 1969		Robert E. Wilson		6 Elroy St. - Wilson	

UNION MEMORIAL HOSPITAL

277 THE AVENUE

FEMALE NERVO

6/10/68 60

RETIRED

BOOTH CAROLINE

JAMES BETHEA

CARRIE TOWSON

JAMES COLE

HYPOCALCAEMIA

ANTHROPOMETRIC OBSERVATIONS

40

JAMES COLE & SON UNION MEMORIAL HOSPITAL

December 28th 68

December 28th 68

Label 11

James Cole & Son

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

A-423		69 12907		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 69 12907	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) <i>Allgood, Lillian Maggie WASHINGTON</i>			
2. DATE AND HOUR OF DEATH <i>12/23/69 8:35 A.M.</i>				3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <i>31 Bon Secours Hospital</i>			
4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>1901</i>				5. SEX <i>Female</i> 6. RACE <i>Negro</i> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			
C. CITY OR TOWN <i>Baltimore</i>				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
E. STREET AND NUMBER <i>204 N. Gilmore Street</i>				FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>31 Bon Secours Hospital</i>			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>DOMESTIC</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Put Family</i>		11. BIRTHPLACE (State or foreign country) <i>Virginia</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>John Washington</i>				14. MOTHER'S MAIDEN NAME <i>Lillian Hill</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>57930-1743</i>		17. INFORMANT <i>Sister Daisy Stroud</i>		ADDRESS <i>WASH. D.C.</i>	
18. <i>412.33</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <i>Coronary Heart Disease</i>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>6 mos?</i>			
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>Heart block (clinical)</i>				(B) DUE TO, OR AS A CONSEQUENCE OF: <i>2 days</i>			
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <i>Complete aortic ather (25) long day</i>							
19A. DATE OF OPERATION <i>2</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>yes</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>yes</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (1) (this hospital) attended the deceased from <i>12, 22 19 69</i> to <i>12, 23 19 69</i> that (1) (we) last saw the deceased alive on <i>12, 23 19 69</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>Varah Vorasubin, M.D.</i>				23B. DATE SIGNED <i>12, 23, 1969</i>		23C. PHYSICIAN'S NAME (Typol) <i>VARAH VORASUBIN, M.D.</i>	
23D. ADDRESS <i>Bon Secours Hosp. Baltimore Maryland</i>				23E. DEGREE			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burn</i>		24B. DATE <i>12/27/69</i>		24C. NAME OF CEMETERY or CREMATORY <i>Bon Secours National</i>		24D. LOCATION (City, town, or county) (State) <i>Baltimore MD</i>	
25A. DATE REC'D BY HEALTH/DEPT. <i>DEC 30 1969</i>		25B. NAME OF REGISTRAR <i>Robert E. Taylor</i>		25C. FUNERAL DIRECTOR <i>Worham D. Jones</i>		ADDRESS <i>638 N. Gilmore St</i>	



69 12308

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

69 12908

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) <b>WILLIAM WESLEY HOBBS</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month <b>December</b> Day <b>26</b> , Year <b>1969</b> Hour <b>M.</b>	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>00</b> <b>822 N. Montford Avenue</b> (If not in hospital or institution, give street address or location)		3. DATE PRONOUNCED DEAD Month <b>December</b> Day <b>26</b> , Year <b>1969</b> Hour <b>2:10 P.</b> M.	
6. SEX <b>Male</b>		7. RACE <b>Negro</b>	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Baltimore</b>	
9. DATE OF BIRTH <b>MARCH 11-1924</b>		10. AGE (In years last birthday) <b>45</b>	
11. BIRTHPLACE (State or foreign country) <b>SUSSEX CO VA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>PETER HOBBS</b>		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>LABORER</b>	
15. MOTHER'S MAIDEN NAME <b>GERALDINE LEWIS</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>YES</b>	
17. SOCIAL SECURITY NO. <b>CONFIDENTIAL</b>		18. INFORMANT ADDRESS <b>Mary Hobbs 1418 N CHESTER ST</b>	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>E966X</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>Stabwound of heart</b> DUE TO, OR AS A CONSEQUENCE OF: (b) _____ (c) _____ OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH _____	
20A. DATE OF OPERATION <b>12/23/69</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED _____	
21. AUTOPSY? (Yes or No) <b>Yes</b>		22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Unknown</b>		22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>Unknown</b>	
22D. TIME (Month) (Day) (Year) (Hour) (Minute) OF INJURY (APPROX.) <b>? ? ? ? ?</b>		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
22F. HOW DID INJURY OCCUR? <b>Stabbed by unknown assailant</b>		23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>	
ACTUAL SIGNATURE <b>Isidore Mihalakis, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Isidore Mihalakis, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Removal</b>		24B. DATE <b>12/23/69</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Panmy Plot</b>		24D. LOCATION (City, town, or county) (State) <b>Sussex Co VA</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 30 1969</b>		25B. NAME OF REGISTRAR <b>Robert E. Jones</b>	
25C. FUNERAL DIRECTOR <b>Franklin P. Jones</b>		ADDRESS <b>138 N. Gilmor St</b>	

N 861.1

FOR MACK B. JONES - STONEY CREEK VA

ACADEMY BOUND

PRO COPY

Mr. K. M. G. G. G.

K. M. G. G. G.

Superior Co. Va.

March 11th 1872

My dear Sir,  
Enclosed please find  
the bill for the  
rent of the  
premises for the  
month of March 1872.

Superior Co. Va.

Yours very truly,  
K. M. G. G. G.

For the  
rent of the  
premises for the  
month of March 1872.

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<div style="display: flex; justify-content: space-between;"> <span>H-400</span> <span>69 12909</span> </div> <div style="display: flex; justify-content: space-between;"> <span>BALTIMORE CITY HEALTH DEPARTMENT</span> <span>CERTIFICATE OF DEATH</span> </div>		REG. NO. <span style="font-size: 1.2em;">69 12909</span>	
1. NAME OF DECEASED (Type or Print) <b>AAH, JEROME</b>		2. DATE AND HOUR OF DEATH <b>1226 1726/69 BRA 3 9 45 A</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>JOHNS HOPKINS HOSP.</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MD</b> B. COUNTY <b>—</b> C. CITY OR TOWN <b>BALTO</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>1620 HARLEM AVE</b>	
5. SEX <b>M</b>	6. RACE <b>N N</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6-11-89</b>
9. AGE (In years lost birthday) <b>80</b>		10. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>OLD CUSTODIAN CHURCH</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>—</b>	
11. BIRTHPLACE (State or foreign country) <b>A. B. Co. MD</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Richard Hall</b>		14. MOTHER'S MAIDEN NAME <b>Margaret Steward</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>212-07-6968</b>	
17. INFORMANT <b>Marymont Hall 1620 Harlem Ave</b>		ADDRESS <b>—</b>	
18. <b>429.91 + 185X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Cardiovascular collapse</b>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Cardiovascular collapse</b> (B) DUE TO, OR AS A CONSEQUENCE OF: <b>—</b> (C) DUE TO, OR AS A CONSEQUENCE OF: <b>—</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>—</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>—</b>	
<b>II</b>			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>metastatic ca of prostate</b>			
19A. DATE OF OPERATION <b>2</b>	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>—</b>	20A. AUTOPSY? (Yes or No) <b>YES</b>	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>NO</b>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>—</b>	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>—</b>	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <b>—</b>	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR? <b>—</b>	
22. I certify that (I) (this hospital) attended the deceased from <b>December 20 1969</b> to <b>December 26 1969</b> , that (I) (we) last saw the deceased alive on <b>December 26 1969</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. <b>(I) (We) (did) (did not) view the body after death.</b>			
23A. SIGNATURE <b>C. Omidyar</b>		23B. DATE SIGNED <b>12/26/69</b>	
23C. PHYSICIAN'S NAME (Type) <b>CYRUS OMIDYAR</b>		23D. ADDRESS <b>Johns Hopkins Hospital</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>12/30/69</b>	24C. NAME OF CEMETERY or CREMATORY <b>Mt Calvary</b>	24D. LOCATION (City, town, or county) (State) <b>Baltimore (Baltimore) 25</b>
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 30 1969</b>	25B. NAME OF REGISTRAR <b>Robert E. Taylor, M.D.</b>	25C. FUNERAL DIRECTOR <b>—</b> ADDRESS <b>—</b>	



1. Attached to the 1st Dec 1914

2. By the 1st Dec 1914

3. By the 1st Dec 1914

4. By the 1st Dec 1914  
5. By the 1st Dec 1914



BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

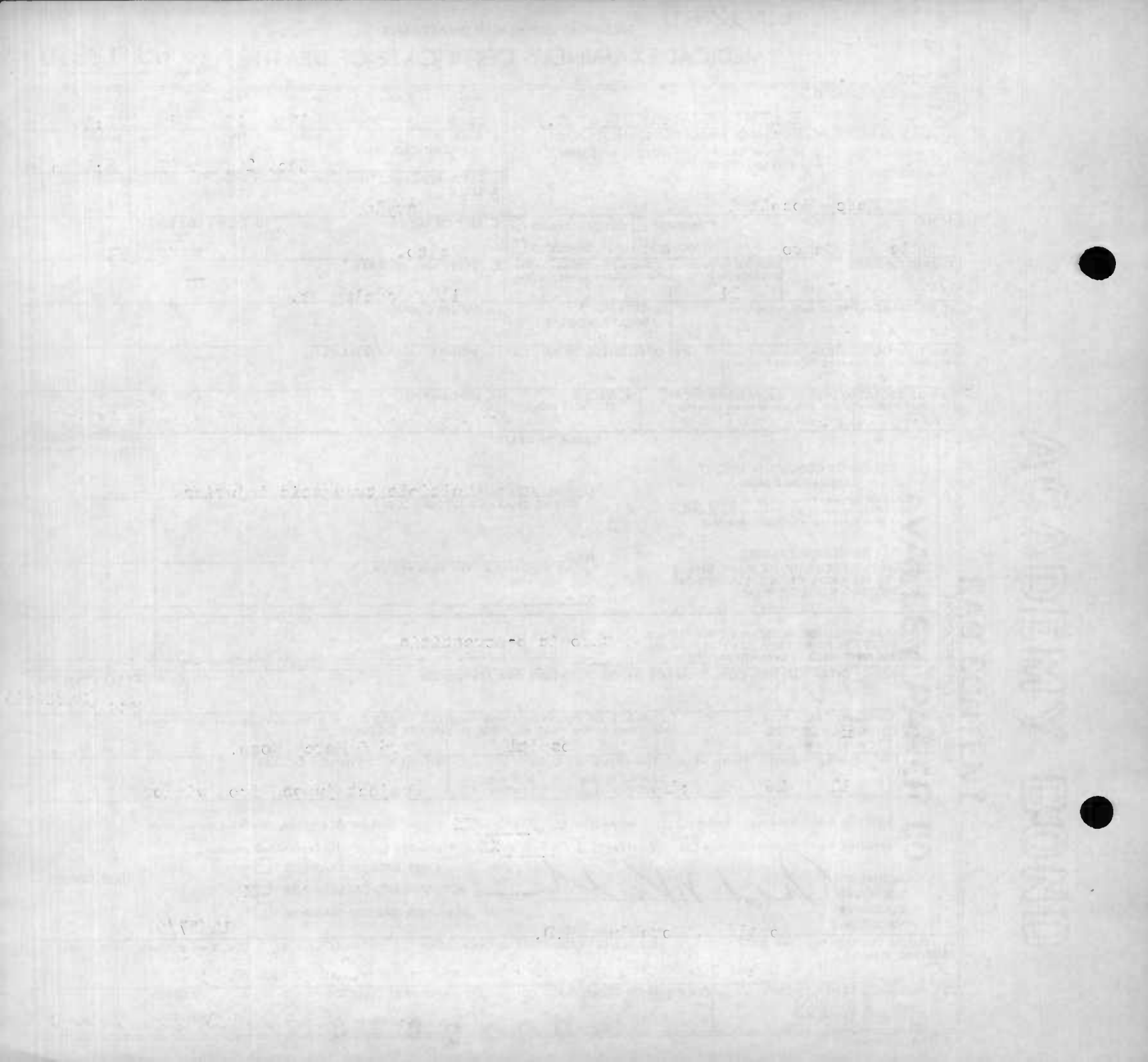
REG. NO. **69 12910**

**BIRTH NO.**

1. NAME OF DECEASED (Type or Print) <b>WILLIAM HOWARD (BILLY C.)</b>		2. DATE OF DEATH Known <input type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour <b>12 26 69 8:18 p. M.</b>	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>37 Mercy Hospital</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>Dec. 26, 1969 8:18 p. M.</b>	
6. SEX <b>Male</b>		7. RACE <b>Negro</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Balto.</b>	
9. DATE OF BIRTH <b>MARCH 3-1935</b>		10. AGE (In years last birthday) <b>31</b>	
11. BIRTHPLACE (State or foreign country) <b>GREENVILLE N.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>LABORER</b>		14B. KIND OF BUSINESS OR INDUSTRY	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>YES 5-31-55 - 3-19-58</b>		17. SOCIAL SECURITY NO.	
18. INFORMANT <b>HELEN HOWARD</b>		ADDRESS <b>770 W. SARATOGA ST.</b>	
19. <b>E957X</b>		CAUSE OF DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE <b>Multiple traumatic injuries</b> DUE TO, OR AS A CONSEQUENCE OF:	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) DUE TO, OR AS A CONSEQUENCE OF:	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		(C)	
20A. DATE OF OPERATION <b>2</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Chronic pancreatitis</b>	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Hospital</b>	
22D. TIME OF INJURY (APPROX.) Month Day Year Hour <b>12 26 69 8:15</b>		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>Ward &amp; Mercy Hosp.</b>		22F. HOW DID INJURY OCCUR? <b>Subject jumped from window</b>	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE OF EXAMINER <b>Ronald N. Kornblum</b> NAME (Type)		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1-2-70</b>	
24C. NAME OF CEMETERY or CREMATORY <b>BALTO NATIONAL</b>		24D. LOCATION (City, town, or county) (State) <b>BALTO MD</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 30 1969</b>		25B. NAME OF REGISTRAR <b>Robert J. Smith</b>	
25C. FUNERAL DIRECTOR <b>Marshall P. Angelo</b>		ADDRESS <b>638 N. GLENVIEW ST</b>	

DATE SIGNED  
**12/27/69**

VS 151-REV. 7/1/68

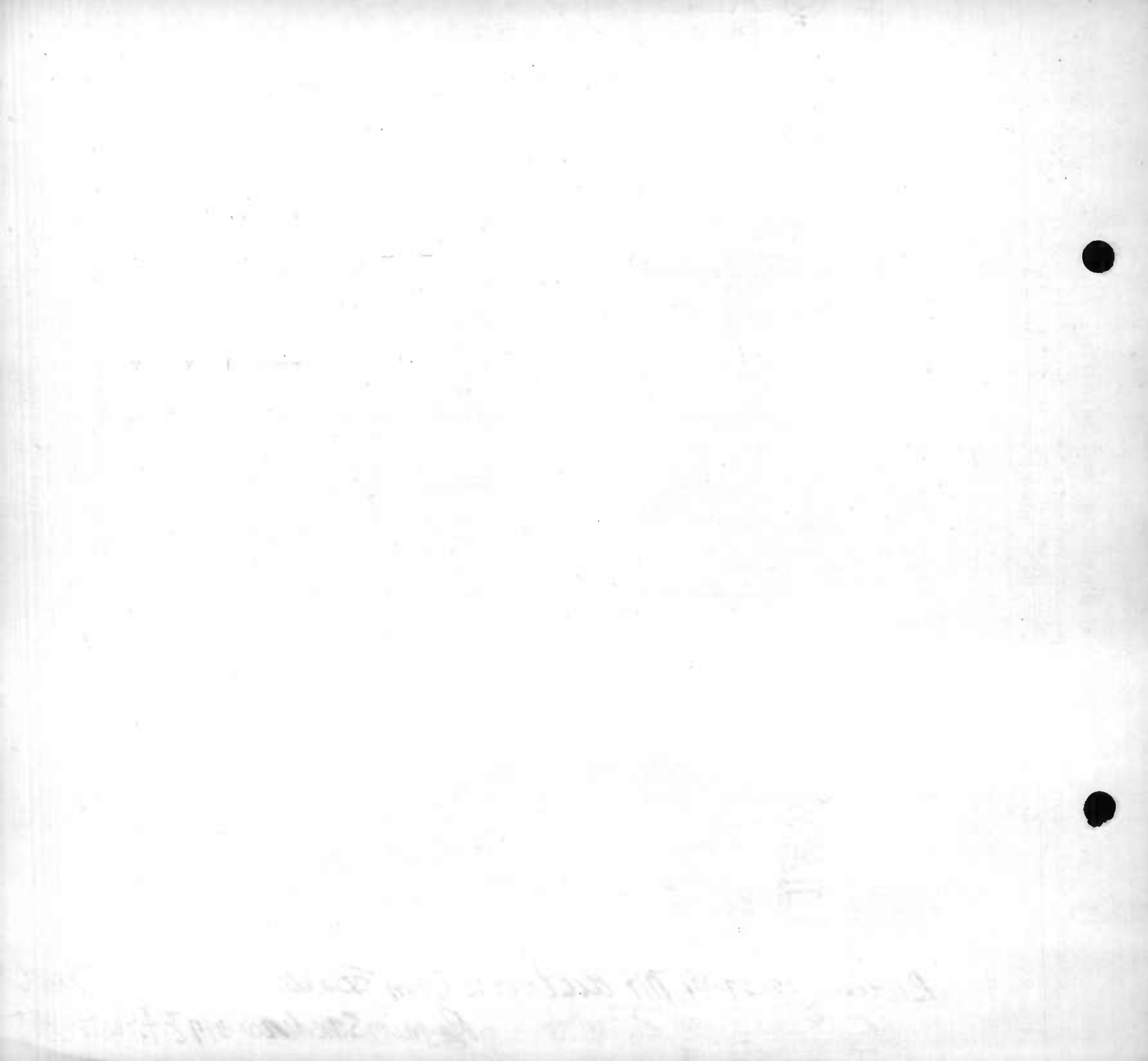


This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT  
69 12911 CERTIFICATE OF DEATH

REG. NO. 69 12911

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>ADA MEYERS Brown</b>		2. DATE AND HOUR OF DEATH <b>Dec. 22 1969 8 55 p.m.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>807</b>	
FULL NAME OF HOSPITAL OR INSTITUTION <b>33 THE JOHNS HOPKINS HOSPITAL</b>				C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				E. STREET AND NUMBER <b>1733 ELLSWORTH ST.</b>	
5. SEX <b>FEMALE</b>	6. RACE <b>NEGRO</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2-2 -97</b>	9. AGE (In years last birthday) <b>72</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Wife</b>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>
13. FATHER'S NAME <b>CHARLES MEYERS</b>			12. CITIZEN OF WHAT COUNTRY?		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT <b>Hospital Record</b> ADDRESS <b>ADDIENNE MEYERS AIREY TAYLOR</b>
18. <b>41321</b> CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>C.V.A.</b>					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>H A S C U D.</b>					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <b>2 no</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>YES</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>12/22 1969</b> to <b>12/22 1969</b> , that (I) (we) last saw the deceased alive on <b>12/22/69</b> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>C Delgado M.D.</b> DEGREE				23B. DATE SIGNED <b>12/22/69</b>	
23C. PHYSICIAN'S NAME (Type) <b>CESAR DELGADO</b> DEGREE				23D. ADDRESS <b>Johns Hopkins Hospital</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12-27-69</b>		24C. NAME of CEMETERY or CREMATORY <b>Mt Auburn Cem</b>	
24D. LOCATION <b>Balto</b>		24E. (City, town, or county) <b>Md</b>		24F. (State) <b>Md</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 30 1969</b>		25B. NAME OF REGISTRAR <b>Robert E. Gabley</b>		25C. FUNERAL DIRECTOR <b>Raymond Sanders</b>	
25D. ADDRESS <b>217 E. Preston St</b>					



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 69 12912	
BIRTH NO. 5-530		69 12912	
1. NAME OF DECEASED (Type or Print) <b>NAOMI SMITH</b>		2. DATE AND HOUR OF DEATH <b>12/24/69 545P</b> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>ANNAPOLIS</b>	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>JOHNS HOPKINS HOSP. BALTIMORE, MD.</b>		C. CITY OR TOWN <b>ANNAPOLIS</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
		E. STREET AND NUMBER <b>5 HARDESTY CT.</b>	
5. SEX <b>F</b>	6. RACE <b>N N</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6-11-25</b>
		9. AGE (In years last birthday) <b>44</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>-</b>	
11. BIRTHPLACE (State or foreign country) <b>MD</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>VERNON SMITH</b>		14. MOTHER'S MAIDEN NAME <b>Lillian Kyler</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
		17. INFORMANT <b>Gregory Smith, Anna Md.</b> ADDRESS	
18. <b>577101</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE <b>LAENNAC'S CIRRHOSIS</b> DUE TO, OR AS A CONSEQUENCE OF: (B) <b>BLEEDING ESOPHAGEAL VARICES</b> DUE TO, OR AS A CONSEQUENCE OF: (C) <b>ALCOHOLISM</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			
19A. DATE OF OPERATION <b>0</b>	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) <b>NO</b>	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>12/7/69</b> 19 to <b>12/24/69</b> 19, that (I) (we) lost the deceased on <b>12/24/69</b> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <b>Jerome L. Rubin</b>		23B. DATE SIGNED <b>12/24/69</b>	
23C. PHYSICIAN'S NAME (Type) <b>JEROME RUBIN</b>		23D. ADDRESS <b>550 N. BROADWAY BALT.</b>	
24A. BURIAL CREMATION REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>12-29-69</b>	24C. NAME OF CEMETERY or CREMATORY <b>Broadneck</b>	24D. LOCATION (City, town, or county) (State) <b>St. Margaret's Md.</b>
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 30 1969</b>	25B. NAME OF REGISTRAR <b>Robert E. J. Rubin</b>	25C. FUNERAL DIRECTOR <b>William Beesett</b>	ADDRESS <b>Anna Md.</b>

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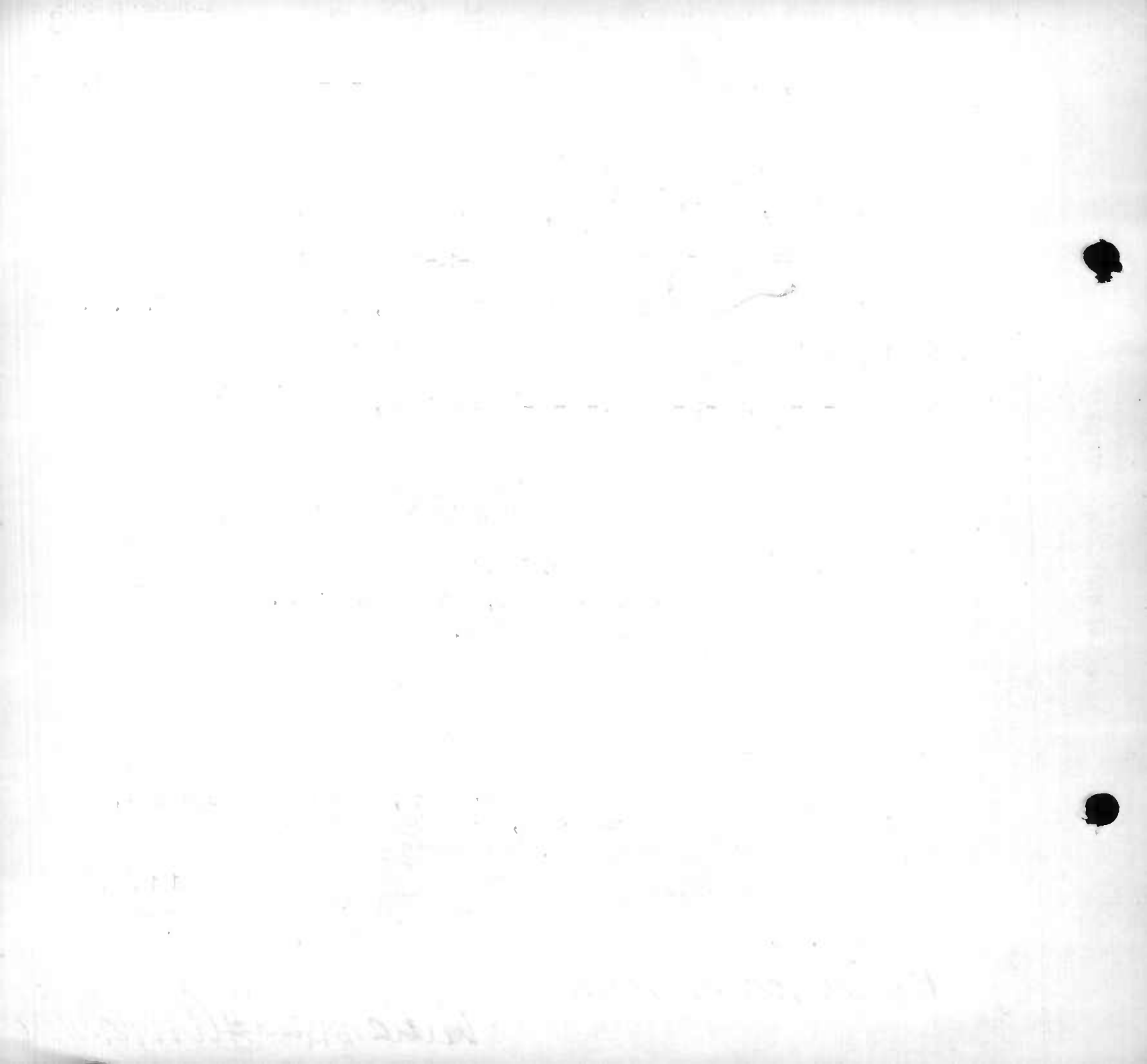
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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<div style="display: flex; justify-content: space-between;"> <span>E-363</span> <span>69 12913</span> <span>BALTIMORE CITY HEALTH DEPARTMENT</span> </div> <div style="display: flex; justify-content: space-between;"> <span>CERTIFICATE OF DEATH</span> <span>REG. NO. 69 12913</span> </div>					
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>EDWARDS, James Henry</b>		2. DATE AND HOUR OF DEATH <b>12-28-69 1:08 A.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>AAO.</b>		5.2.10	
FULL NAME OF HOSPITAL OR INSTITUTION <b>23 Veterans Administration Hospital</b> <b>3900 Loch Raven Boulevard</b> <b>Baltimore, Maryland 21218</b>		C. CITY OR TOWN <b>Annapolis</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <b>67 Calvert Street</b>		6. DATE OF BIRTH <b>8-12-20</b>		9. AGE (In years last birthday) <b>49</b>	
5. SEX <b>Male</b>		6. RACE <b>Negro</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Truck Driver</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Waterburg, Maryland</b>	
13. FATHER'S NAME <b>Richard Edwards</b>		14. MOTHER'S MAIDEN NAME <b>Rachel Watkins</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes 3-23-44 to 3-10-45</b>		16. SOCIAL SECURITY NO. <b>214-18-08-74</b>		17. INFORMANT <b>VA Hospital Records</b> <b>Baltimore, Maryland 21218</b>	
18. <b>571.0 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>CHRONIC ALCOHOLISM</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. <b>NUTRITIONAL CIRRHOSIS</b> <b>ESOPHAGEAL VARICES</b> <b>HEPATIC COMA</b>		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>PANCREATITIS, HEMORRHAGIC RECENT.</b> <b>PULMONARY EDEMA.</b>					
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>Yes</b>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>December 15, 19 69</b> to <b>December 28, 19 69</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>December 28, 19 69</b> and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) <input checked="" type="checkbox"/> (did not) view the body after death.					
23A. SIGNATURE <b>Michael G. Hayes, MD</b>				23B. DATE SIGNED <b>21 12/28/69</b>	
23C. PHYSICIAN'S NAME (Type) <b>MICHAEL G. HAYES</b>		23D. ADDRESS <b>3900 Loch Raven Boulevard</b> <b>Baltimore, Maryland 21218</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12-31-69</b>		24C. NAME OF CEMETERY or CREMATORY <b>John Wesley</b>	
24D. LOCATION (City, town, or county) <b>Waterbury</b>		24E. NAME OF REGISTRAR <b>Robert E. Talbot</b>		24F. FUNERAL DIRECTOR <b>William Beese</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 30 1969</b>		25B. NAME OF REGISTRAR <b>Robert E. Talbot</b>		25C. FUNERAL DIRECTOR <b>William Beese</b>	





B-4501

69 12914

BALTIMORE CITY HEALTH DEPARTMENT

## CERTIFICATE OF DEATH

REG. NO.

69 12914

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Marie Bellamy

2. DATE AND HOUR OF DEATH

12-25-69

9:15 P M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

37 Mercy Hospital

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)  
A. STATE B. COUNTY

Md.

908

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☐NO ☐

E. STREET AND NUMBER

1905 Aisquith St.

5. SEX

F

6. RACE

N

7. MARRIED ☐NEVER MARRIED ☐WIDOWED ☒DIVORCED ☐

8. DATE OF BIRTH

6-15-92

9. AGE (in years  
last birthday)

77

if Under 1 Yr.  
Months Daysif Under 24 Hrs.  
Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Virginia

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Hawthorn

14. MOTHER'S MAIDEN NAME

Unknown

15. Was Deceased Ever in U. S. Armed Forces?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Mrs Williams 5440 Redcrest Ave

18. 412.21

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, ashenia, etc. It means the disease,  
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving  
rise to the above cause (A) stating the  
UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATHII  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART I (A).

Arteriosclerosis

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING  
OR CONTRIBUTING CAUSE OF  
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME  
OF INJURY  
(Month) (Day) (Year) (Hour)  
(APPROX.)

21E. INJURY OCCURRED

White At  
Work ☐Not White  
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (the hospital) attended the deceased from March 19 62 to December 19 69  
that (I) (we) last saw the deceased alive on Oct. 19 69 and that in (my) (our) opinion death occurred on the date  
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Jesse T. Holmes MD

Attending  
Phys. ☐Med.  
Director ☐Staff  
Phys. ☐

23B. DATE SIGNED

Dec 28, 1969

23C. PHYSICIAN'S  
NAME (Type)

Jesse T. Holmes

23D. ADDRESS

508 E North Ave

24A. BURIAL CREMATION,  
REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY or CREMATORY

24D. LOCATION

(City, town, or county)

(State)

Burial

12-29-69

Mt Airy Cem Balto

MD

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

DEC 30 1969

R. E. Faber, M.D.

Raymond Sanders 517 E. Preston St

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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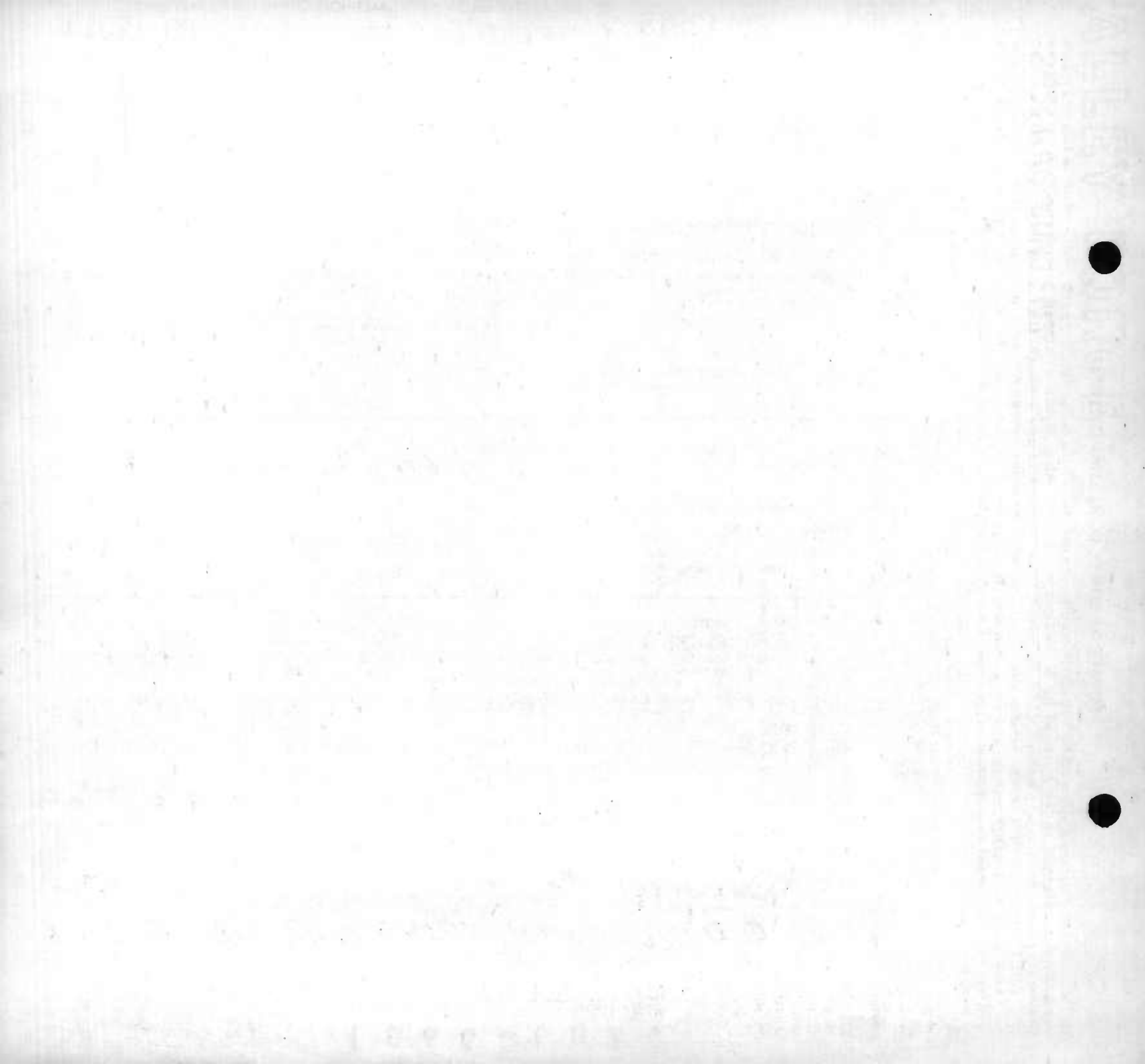
12-21-8  
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12-21-8

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-650 69 12915				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 69 12915	
BIRTH NO.				1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
				LOUISE BROWN		12/ 26/69	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY		M.	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				Maryland		1502	
00 1644 N Monroe Street				C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 1644 N Monroe Street			
5. SEX F		6. RACE C		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7/31/80	
				9. AGE (In years lost in infancy) 88		If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Centerville Md	
12. CITIZEN OF WHAT COUNTRY? U S A				13. FATHER'S NAME Fred Brown			
14. MOTHER'S MAIDEN NAME Rita Brown				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO.				17. INFORMANT MRs Barbara Brown, same			
18. 481X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Lobar Pneumonia		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 days	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 3 Jan 1969 to 23 Dec 1969, that (I) (we) last saw the deceased alive on 24 Dec 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE G. C. Sewell M.D.				23B. DATE SIGNED 12/27/69			
23C. PHYSICIAN'S NAME (Type) A. C. BURWELL M.D.				23D. ADDRESS 1924 W North Ave Baltimore Md			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/30/69		24C. NAME OF CEMETERY or CREMATORY Darver Mem Park		24D. LOCATION (City, town, or county) (State) Laurel Md	
25A. DATE REC'D BY HEALTH DEPT. DEC 30 1969		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR H. J. Holstead		ADDRESS 1206 W north Ave	



## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

C-400		69 12916		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 69 12916	
BIRTH NO.				2			
1. NAME OF DECEASED (Type or Print) <b>COLEA, VERNON C</b>				2. DATE AND HOUR OF DEATH <b>DEC 25 1969 1500 A</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <b>31 Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224</b>				A. STATE <b>Maryland</b> B. COUNTY <b>2841</b>			
				C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <b>4901 Bell Avenue 21207</b>			
5. SEX <b>Male</b>	6. RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>10-23-1900</b>	9. AGE (In years last birthday) <b>69</b>	10. Under 1 Yr. Months: Days: Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>North Carolina</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				13. FATHER'S NAME <b>Will</b>			
14. MOTHER'S MAIDEN NAME <b>Anna</b>				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. <b>112-05-8369A</b>				17. INFORMANT ADDRESS <b>Records: BCH-4940 Eastern Avenue 21224</b>			
18. <b>150X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>PNEUMONIA</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>CARCINOMA OF ESOPHAGUS</b> II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>PNEUMONIA</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>4 WEEKS</b>	
				(B) <b>CARCINOMA OF ESOPHAGUS</b> DUE TO, OR AS A CONSEQUENCE OF: <b>6 Wks.</b>			
				(C) _____			
MEDICAL CERTIFICATION							
19A. DATE OF OPERATION <b>NOV 28 '69</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>CARCINOMA ESOPHAGUS</b>		20A. AUTOPSY (Yes or No) <b>NO</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that <del>at</del> (this hospital) attended the deceased from <b>NOV 16</b> <b>1969</b> to <b>DEC 25</b> <b>1969</b> that <del>at</del> (we) last saw the deceased alive on <b>DEC 25</b> <b>1969</b> and that <del>in</del> (our) opinion death occurred on the date and hour and from the causes stated above. ( <del>at</del> (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Rolf H. Bessin M.D.</b>				23B. DATE SIGNED <b>Dec 25 1969</b>			
23C. PHYSICIAN'S NAME (Type) <b>Rolf H. Bessin</b>				23D. ADDRESS <b>4940 Eastern Avenue, Baltimore, Maryland 21224</b>			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <b>12/30/69</b>		24C. NAME OF CEMETERY OR CREMATORY <b>NA. Auburn Cem.</b>		24D. LOCATION (City, town, or county) (State) <b>Balt. Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 30 1969</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor, M.D.</b>		25C. FUNERAL DIRECTOR <b>1712 W. North Ave</b>		ADDRESS	



R-360

3

FUNERAL DIRECTOR: IMPORTANT

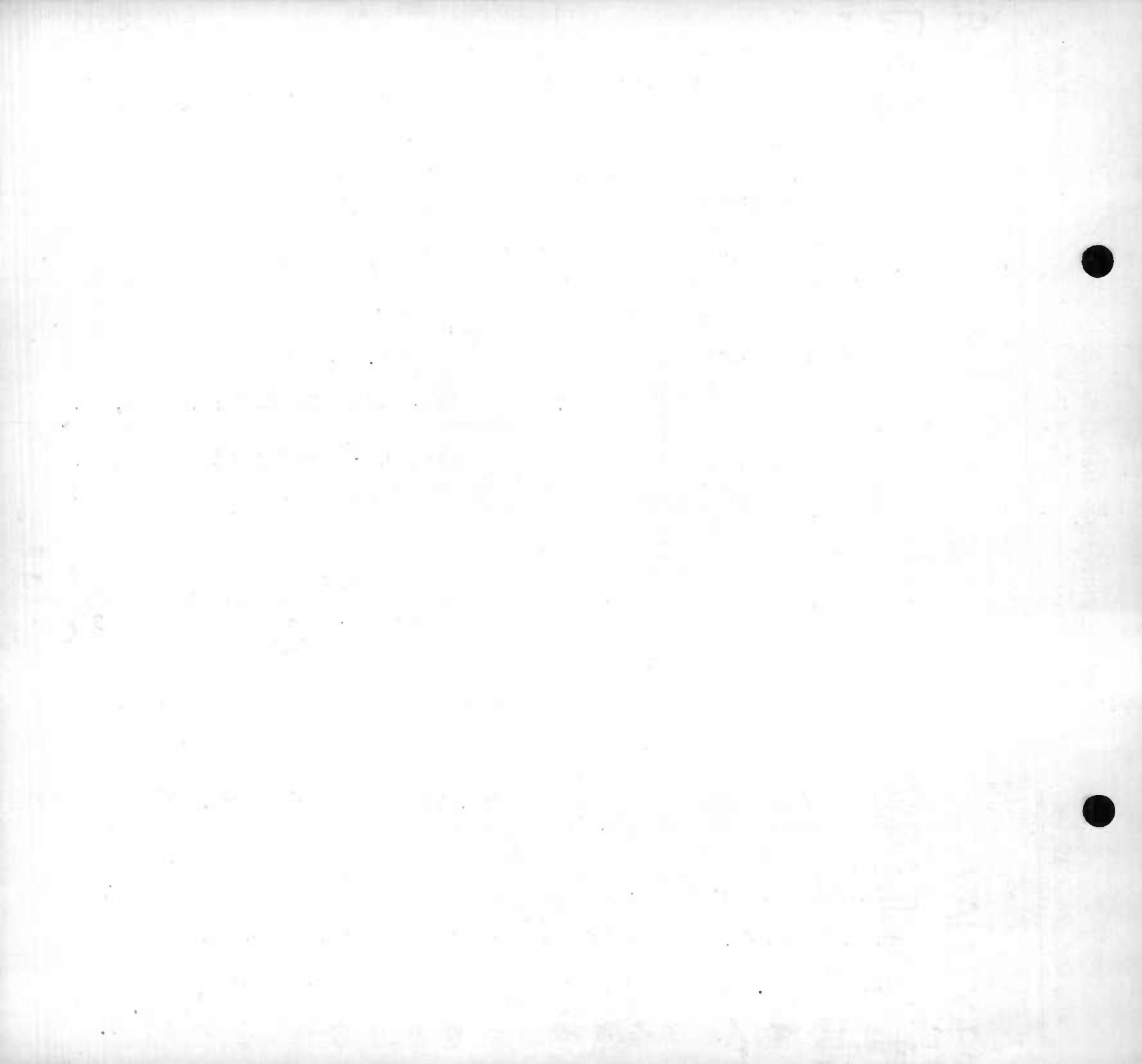
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

RGB

BALTIMORE CITY HEALTH DEPARTMENT  
69 12917 CERTIFICATE OF DEATH

REG. NO. 69 12917

BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		George Michael Rutter		Dec. 29, 1969 11 A M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE B. COUNTY			
US Public Health Service Hospital 2X 3100 Wyman Parkway		Md. Howard Ellicott City 6300			
		C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
		Ellicott City		YES <input type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER			
		5915 Gales Lane			
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years lost birthday)	10. CITIZEN OF WHAT COUNTRY?
M	W	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9/8/52	17	USA
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Student				Md.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME			
Joseph Rutter		Margaret Schmidt			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No		?		Records- US PHS Hospital, Balto, Md.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asphemia, etc. It means the disease, injury or complication which caused death.)		Hodgkin's disease( 4 B )		2 yrs.	
ANTECEDENT CAUSES		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF:			
II		Marfan's syndrome		Life	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
0		no			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?			
	While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				
22. I certify that (1) (this hospital) attended the deceased from Aug. 20 1969 to Dec. 29 1969, that (1) (we) last saw the deceased alive on Dec. 29 1969 and that in (1) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
William E. Mitch J				12/29/69	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
Wm. E. Mitch, Jr. Surgeon (R)		US PHS Hospital, Balto, Md.			
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)		
Burial	Dec. 31, 1969	Crest Lawn	Marriottsville, Md		
25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR ADDRESS			
DEC 30 1969	Robert E. J. [illegible]	Howard County Fun. Home Harry Witzke Ellicott City Md.			





# FUNERAL DIRECTOR: IMPORTANT

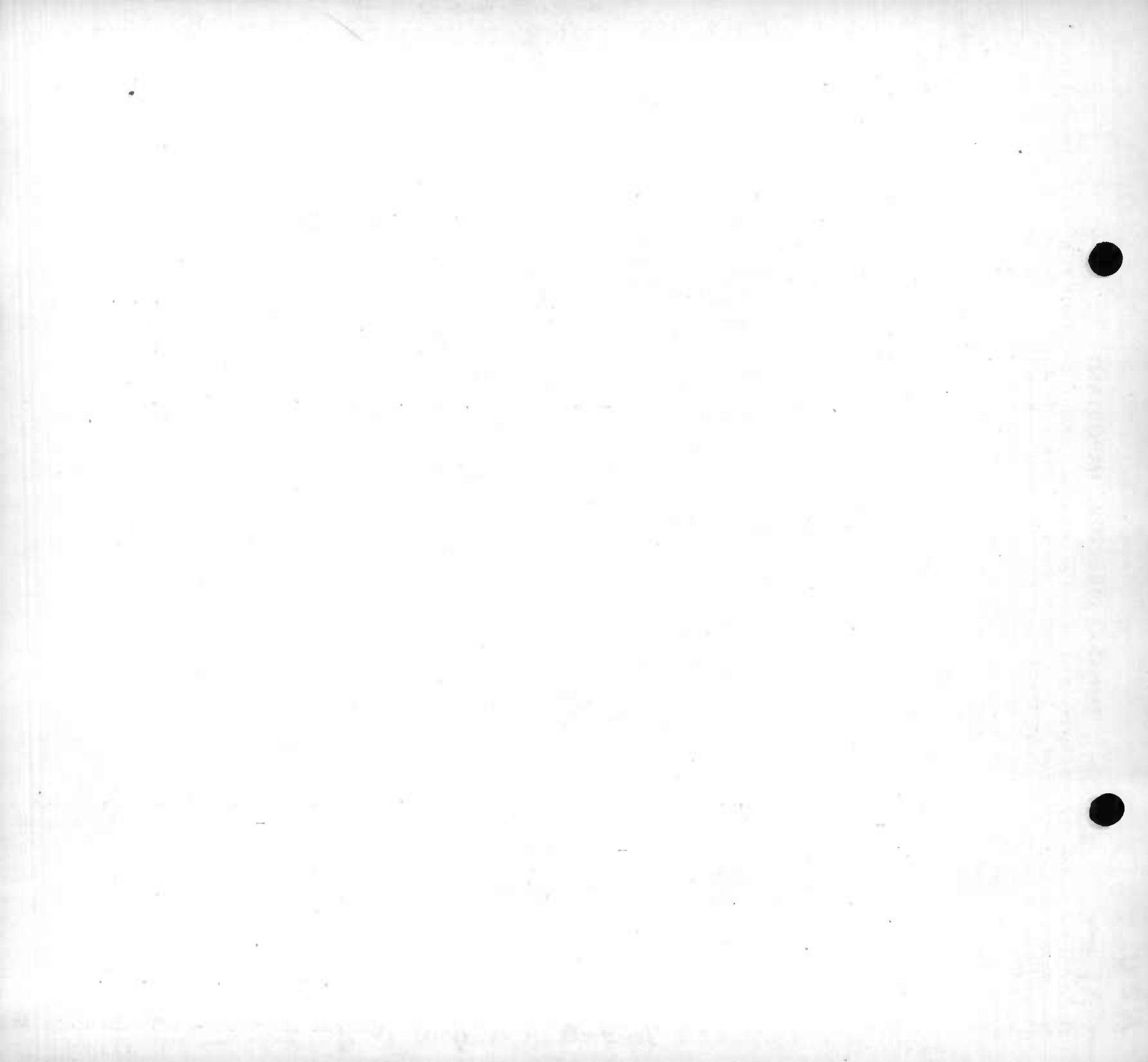
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

69 12918

## BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

REG. NO. 69 12918

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>Anna M. Franklin</b>		2. DATE AND HOUR OF DEATH <b>12/27/69</b>   <b>7:00 P.</b> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>90 Gould Nursing Home</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Baltimore</b> B. COUNTY <b>2734</b> C. CITY OR TOWN <b>Maryland</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>6116 Belair Road</b>		
5. SEX <b>Female</b>	6. RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7/15/75</b>	9. AGE (In years last birthday) <b>94</b>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			13. FATHER'S NAME <b>August Porcher</b>		
14. MOTHER'S MAIDEN NAME <b>Margaretta</b>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>		
16. SOCIAL SECURITY NO. <b>215-48-2517</b>			17. INFORMANT <b>W. Conrad Bishop - Glen Arm Rd. Route 2</b> <b>Glen Arm, Md.</b>		
18. <b>412.4 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>Arteriosclerotic cardiovascular disease</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF (B) DUE TO, OR AS A CONSEQUENCE OF: (C) <b>15 yrs.</b>		
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <b>March 24, 1964</b> to <b>December 27, 1969</b> , that (I) ( <del>we</del> ) last saw the deceased alive on <b>December 8, 1969</b> and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>we</del> ) ( <del>did</del> ) ( <del>not</del> ) view the body after death.					
23A. SIGNATURE <b>Lloyd E. Saylor, M.D.</b>				23B. DATE SIGNED <b>Dec. 30, 1969</b>	
23C. PHYSICIAN'S NAME (Type) <b>Dr. Saylor</b>		23D. ADDRESS <b>3902 Greenmount Ave.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12/31/69</b>		24C. NAME of CEMETERY or CREMATORY <b>Loudon Park</b>	
24D. LOCATION (City, town, or county) (State) <b>Frederick Ave. Balto. Md.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>DEC 30 1969</b>			
25B. NAME OF REGISTRAR <b>Witzke Funeral Directors</b>		25C. FUNERAL DIRECTOR <b>4101 Edmondson Ave</b>			
25D. ADDRESS <b>21229</b>					



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

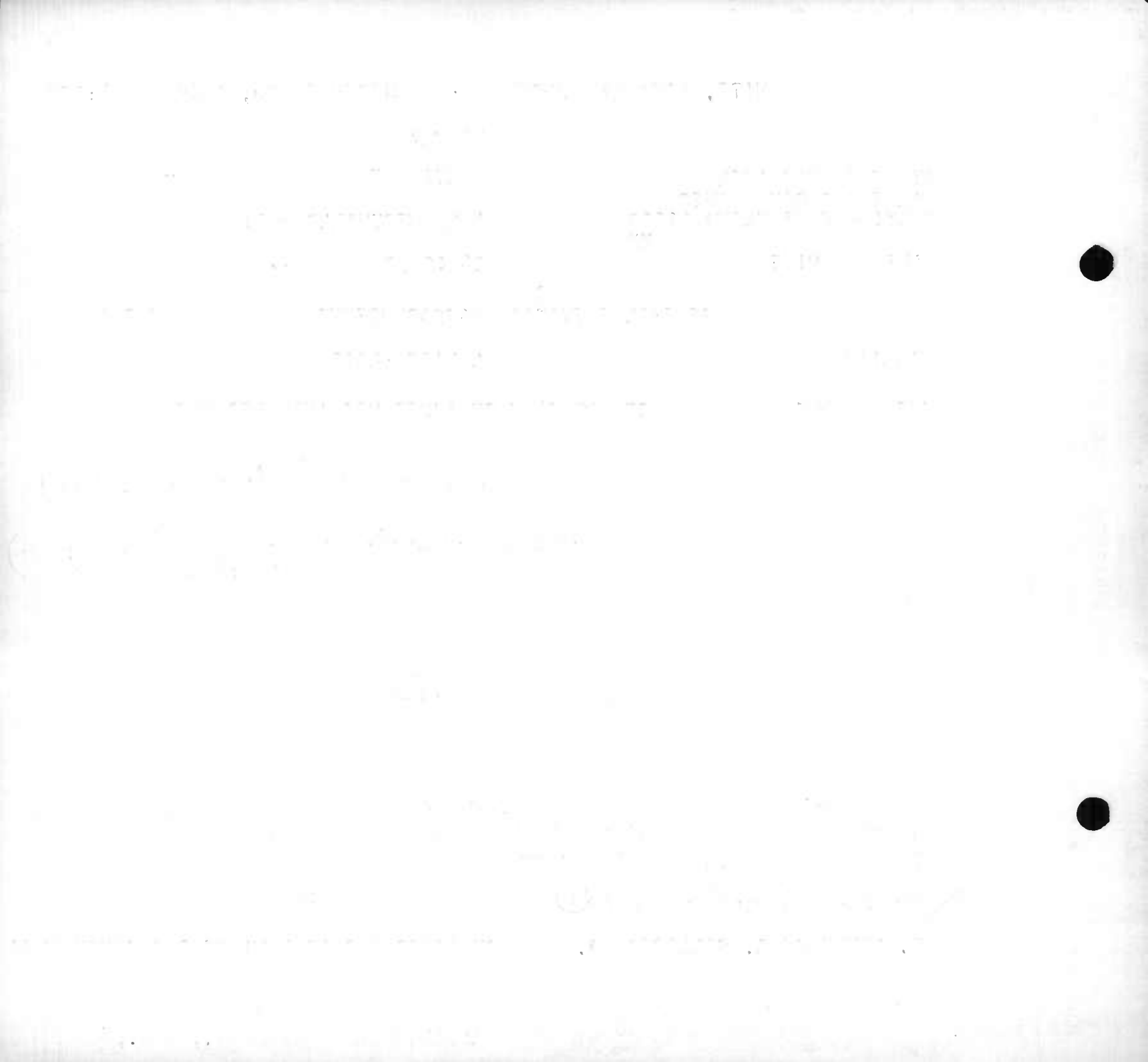
BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 69 12919	
BIRTH NO. 69 12919		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <b>CHARLES LIBERTO</b>		2. DATE AND HOUR OF DEATH <b>12-28-69 11:23 A.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MD.</b> B. COUNTY <b>Baltimore</b>	
FULL NAME OF HOSPITAL OR INSTITUTION <b>MERCY Hospital</b>		C. CITY OR TOWN <b>BALTO.</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		E. STREET AND NUMBER <b>1928 Rockwell Ave.</b>	
5. SEX <b>m</b>	6. RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1-23-11</b> 9. AGE (in years last birthday) <b>58</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country) <b>Baltimore</b>	
10B. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY	
13. FATHER'S NAME <b>John Liberto</b>		14. MOTHER'S MAIDEN NAME <b>MARY ALACIO</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>218-03-3066</b>	
		17. INFORMANT ADDRESS <b>Mrs. Salvatore Cascio, 1928 Rockwell Ave.</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>427.21</b> <b>RENAL FAILURE</b> <b>CEREBRAL DAMAGE</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>CHRONIC PYELONEPHRITIS, ACIDOSIS, AZOTEMIA</b>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>ANEMIA, CARDIAL ARREST</b>			
19A. DATE OF OPERATION <b>12-27-69</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) <input type="checkbox"/>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>12-27-69</b> to <b>12-28-69</b> that (I) (we) lost saw the deceased alive on <b>12-28-69</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <b>Aidan E. Walsh</b>		23B. DATE SIGNED <b>12-28-69</b>	
23C. PHYSICIAN'S NAME (Type) <b>AIDAN E. WALSH MD</b>		23D. ADDRESS <b>222 ST. PAUL</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1/2/70</b>	
24C. NAME of CEMETERY or CREMATORY <b>New Cathedral</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 30 1969</b>		25B. NAME OF REGISTRAR <b>Robert E. Kelly</b>	
25C. FUNERAL DIRECTOR <b>Harvey W. Kipp</b>		25D. ADDRESS <b>1230 Edmondson Ave. Baltimore, MD 21209</b>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

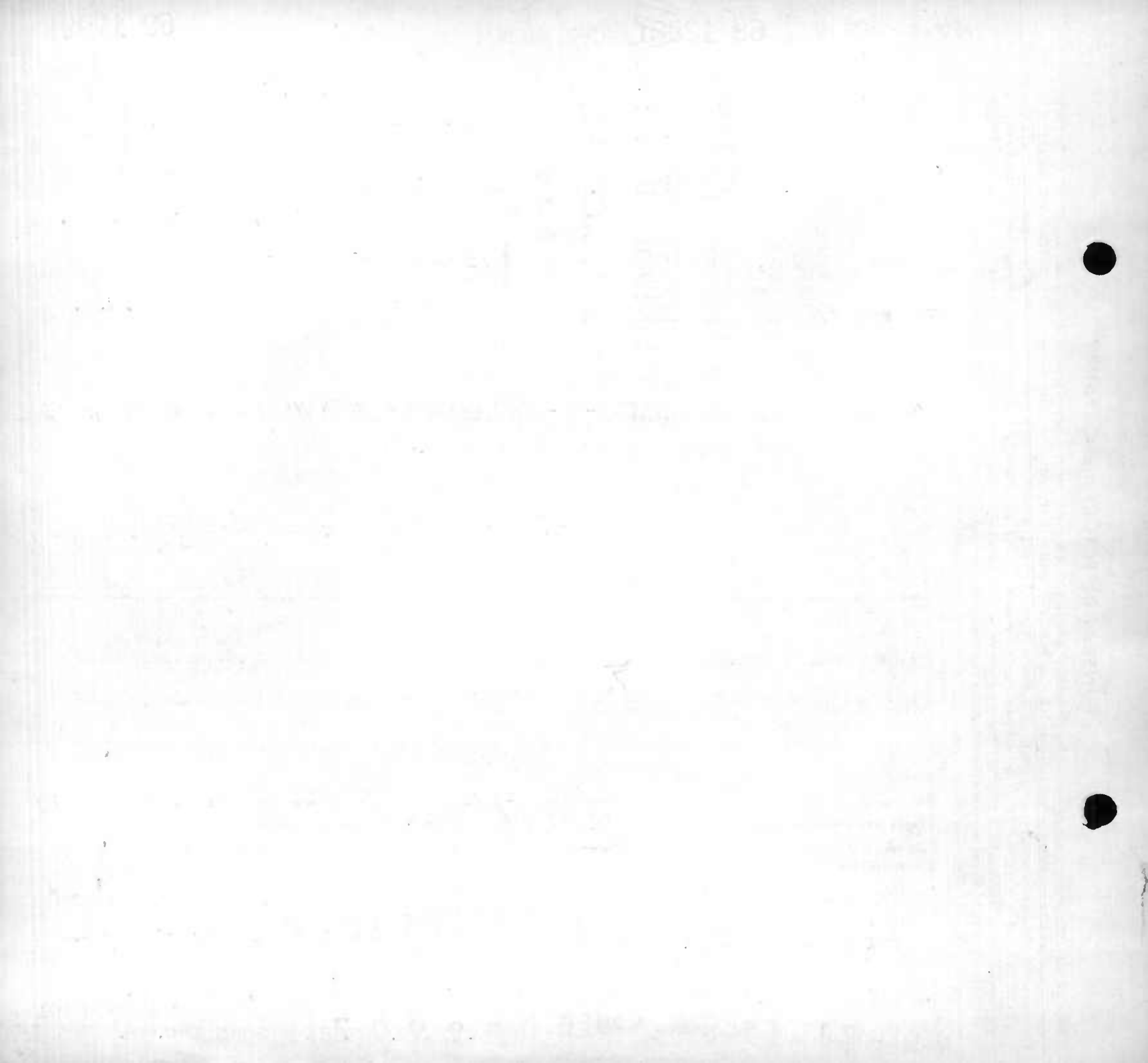
BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. <u>69 12920</u>	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
WHITE, RAYMOND ARTHUR		DECEMBER 28, 1969		4:35P M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION ST AGNES HOSPITAL WILKENS & CATON AVES BALTIMORE MARYLAND 21229		A. STATE MARYLAND		B. COUNTY 2834	
		C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER 4929 WESTHILLS ROAD			
5. SEX MALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 04 12 97	9. AGE (In years last birthday) 72	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY GENERAL ELEVATOR		11. BIRTHPLACE (State or foreign country) MASSACHUSETTS	
13. FATHER'S NAME WILLIAM		14. MOTHER'S MAIDEN NAME LOUISE BLAIR		12. CITIZEN OF WHAT COUNTRY? U S A	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES WW1		16. SOCIAL SECURITY NO. 578 07 5485		17. INFORMANT ST AGNES HOSPITAL RECORDS	
18. <u>410.91</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>myocardial infarction, acute</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>Anterior descending coronary artery</u> DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>(days)</u> <u>(year)</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from <u>27 Dec 1969</u> to <u>28 Dec 1969</u> that (1) (we) last saw the deceased alive on <u>28 Dec 1969</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Laurence R. Gallagher, M.D.</u>		23B. DATE SIGNED 28 Dec 69		23C. PHYSICIAN'S NAME (Type) DR. LAURENCE R. GALLAGHER MD.	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 12/31/69		24C. NAME OF CEMETERY or CREMATORY New Cathedral	
24D. LOCATION (City, town, or county) (State) Baltimore, Maryland		24E. ADDRESS ST AGNES HOSPITAL WILKENS & CATON AVES		24F. ADDRESS Edmondson Av., Bal to., 21228	
25A. DATE REC'D BY HEALTH DEPT. DEC 30 1969		25B. NAME OF REGISTRAR P. E. F. Talley, Jr.		25C. FUNERAL DIRECTOR Mitze, O. G.	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

M-252		69 12921		BALTIMORE CITY HEALTH DEPARTMENT		X		REG. NO.		69 12921	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) MEKINSKI EMILIA				2. DATE AND HOUR OF DEATH 12/27/69 M.					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE				5.300			
FULL NAME OF HOSPITAL OR INSTITUTION 31 BALTIMORE CITY HOSP.				C. CITY OR TOWN BALTIMORE				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				E. STREET AND NUMBER 2421 MEADOW ROAD, BALTIMORE, MD.							
5. SEX FEMALE		6. RACE CAU.		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12-24-1995		9. AGE (In years lost birth day) 74		If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE				10B. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) POLAND		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME OL SZEWSKI				14. MOTHER'S MAIDEN NAME (UNKNOWN)							
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO				16. SOCIAL SECURITY NO. 217-03-3740		17. INFORMANT ADDRESS ANTHONY MEKINSKI 2421 MEADOW RD					
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 412.4 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH Arteriosclerosis C. V. Disease (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: GENERALIZED ARTERIOSCLEROSIS (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH UNKNOWN UNKNOWN			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).											
19A. DATE OF OPERATION 0				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 3/16 1966 to 12/27 1969, that (I) (we) last saw the deceased alive on 12/27/1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.											
23A. SIGNATURE Henry J. Houska				23B. DATE SIGNED 12/29/69				23C. PHYSICIAN'S NAME (Type) HENRY J. HOUSKA M.D.			
23D. ADDRESS 333 S. EAST AVE BALTO MD				24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL				24B. DATE 12/31/69			
24C. NAME OF CEMETERY or CREMATORY HOLY ROSARY CEMETERY				24D. LOCATION DUNDALK, MARYLAND				25A. DATE REC'D BY HEALTH DEPT. DEC 30 1969			
25B. NAME OF REGISTRAR Robert E. Taylor, M.D.				25C. FUNERAL DIRECTOR JOHN M. OWEVER & SONS INC.				ADDRESS 401 S. CHESTER			

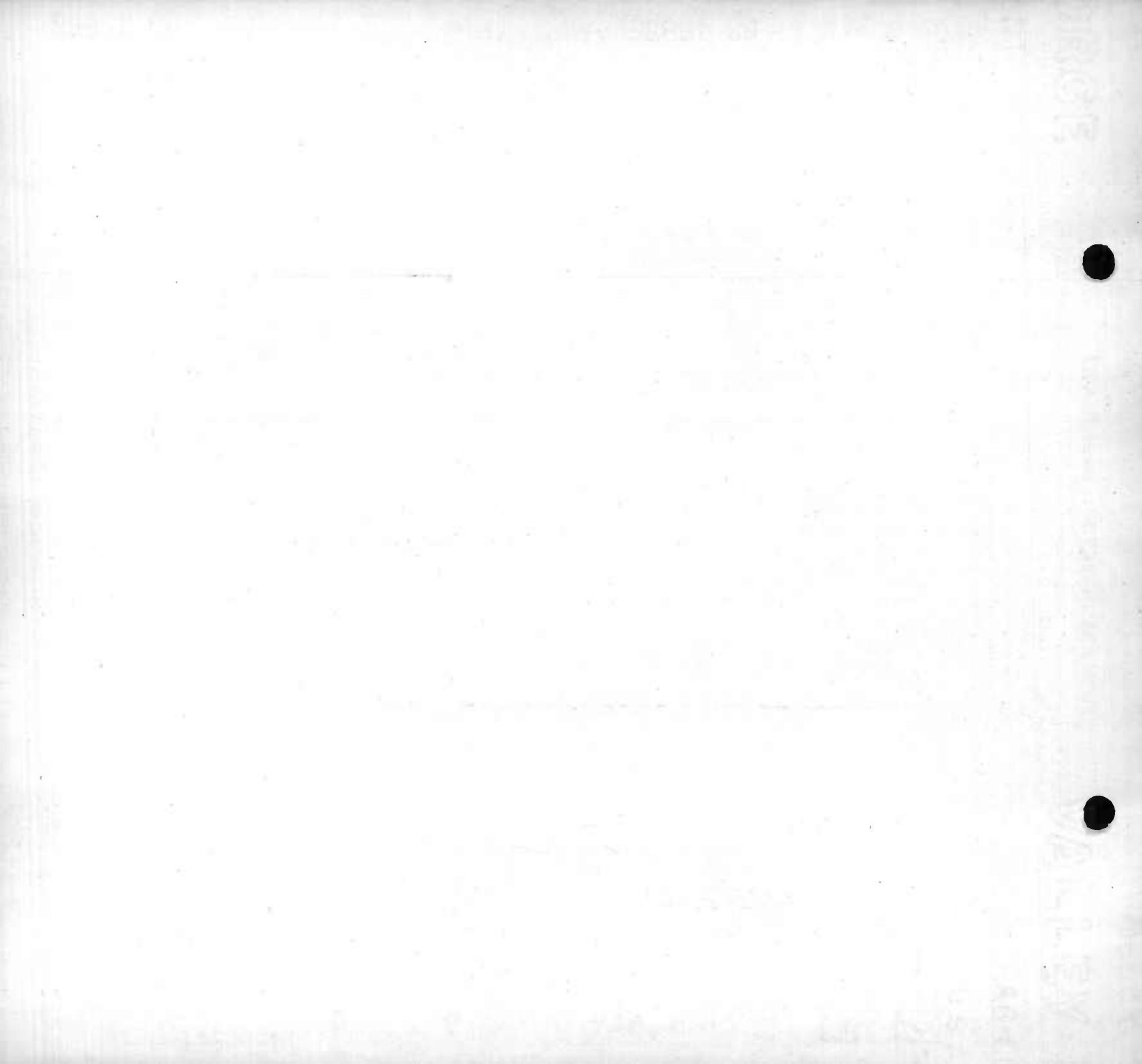




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

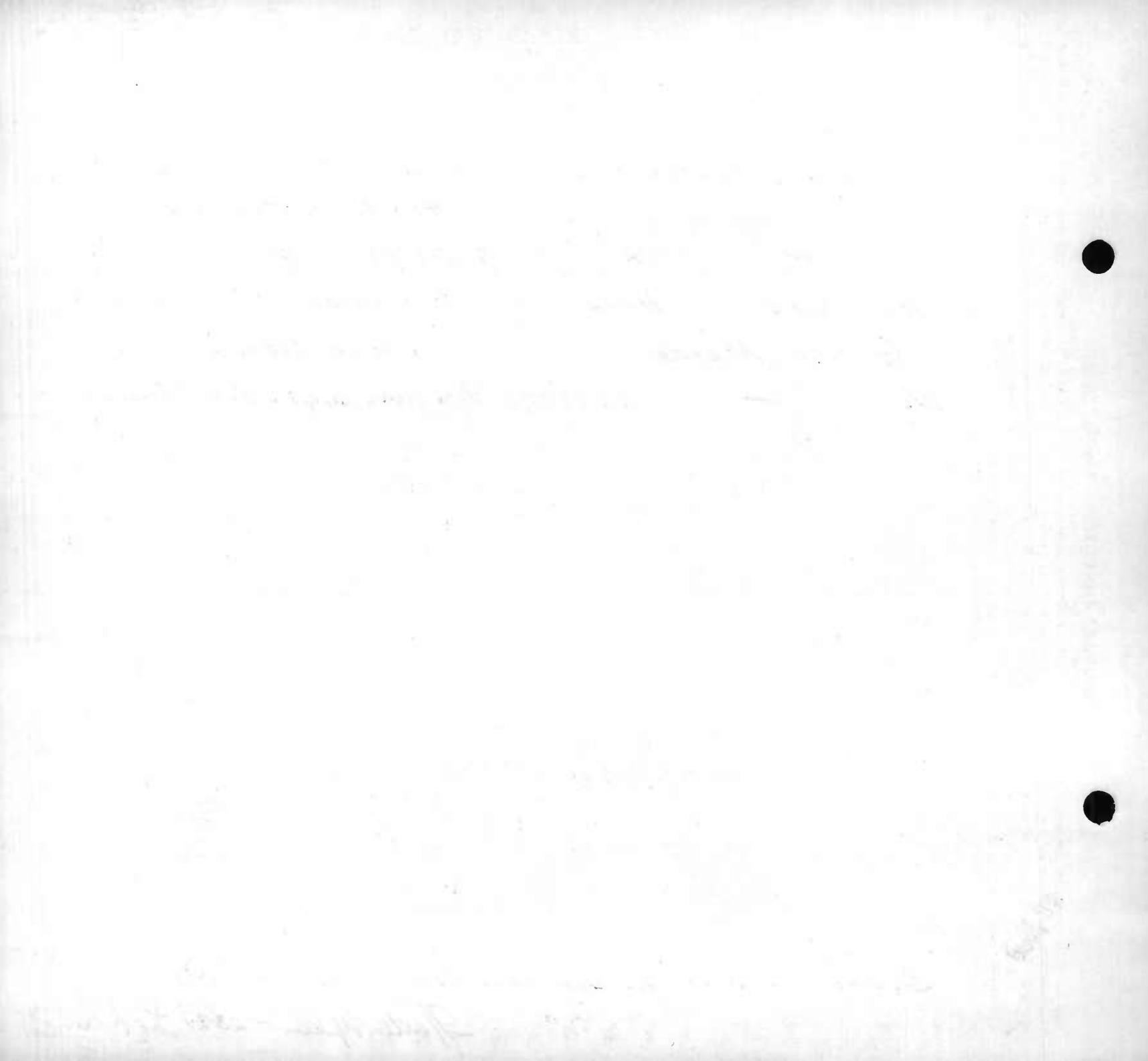
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 69 12922	
<div style="display: flex; justify-content: space-between;"> <span>W-614 69 12922</span> <span>CERTIFICATE OF DEATH</span> </div>					
1. NAME OF DECEASED (Type or Print) <i>Warfield Cynthia L.</i>		2. DATE AND HOUR OF DEATH <i>12/24/69 8:33 A.M.</i>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>2841</i>			
FULL NAME OF HOSPITAL OR INSTITUTION <i>33 The Johns Hopkins Hospital</i>		C. CITY OR TOWN <i>Baltimore</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER <i>3903 Milford Avenue</i>			
5. SEX <i>Female</i>	6. RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <i>8/09/69</i>	9. AGE (In years lost birthday)	If Under 1 Yr. Months <i>4</i> Days <i>15</i> Hours <i>15</i> Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
13. FATHER'S NAME <i>Donald Warfield</i>		14. MOTHER'S MAIDEN NAME <i>Dolores Dawson</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
<div style="display: flex;"> <div style="flex: 1;"> <p>18. <i>751.51</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)</p> <p>ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.</p> </div> <div style="flex: 1;"> <p>CAUSE OF DEATH</p> <p>(A) IMMEDIATE CAUSE <i>Aspiration</i> DUE TO, OR AS A CONSEQUENCE OF:</p> <p>(B) <i>Biliary atresia</i> DUE TO, OR AS A CONSEQUENCE OF:</p> <p>(C) _____</p> </div> <div style="flex: 1;"> <p>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</p> </div> </div>					
<p>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</p>					
19A. DATE OF OPERATION <i>2</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>YES</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
<p>22. I certify that (I) (<del>this hospital</del>) attended the deceased from <i>12/19</i> 19<i>69</i> to <i>12/24</i> 19<i>69</i>, that (I) (<del>we</del>) last saw the deceased alive on <i>12/24</i> 19<i>69</i> and that in (my) (<del>our</del>) opinion death occurred on the date and hour and from the causes stated above. (I) (<del>we</del>) (<del>did not</del>) view the body after death.</p>					
23A. SIGNATURE <i>Jay W. Pettegrew</i>		23B. DATE SIGNED <i>12/24/69</i>		23C. PHYSICIAN'S NAME (Type) <i>Jay W. Pettegrew</i>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Cremation</i>		24B. DATE <i>12/24/69</i>		24C. NAME OF CEMETERY or CREMATORY <i>Retained by Johns Hopkins Hospital</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>DEC 30 1969</i>		25B. NAME OF REGISTRAR <i>Robert E. Fisher, R.D.</i>		25C. FUNERAL DIRECTOR <i>0 0 0 9 0 0 0</i>	
<p>HOSPITAL DISPOSAL</p>					



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

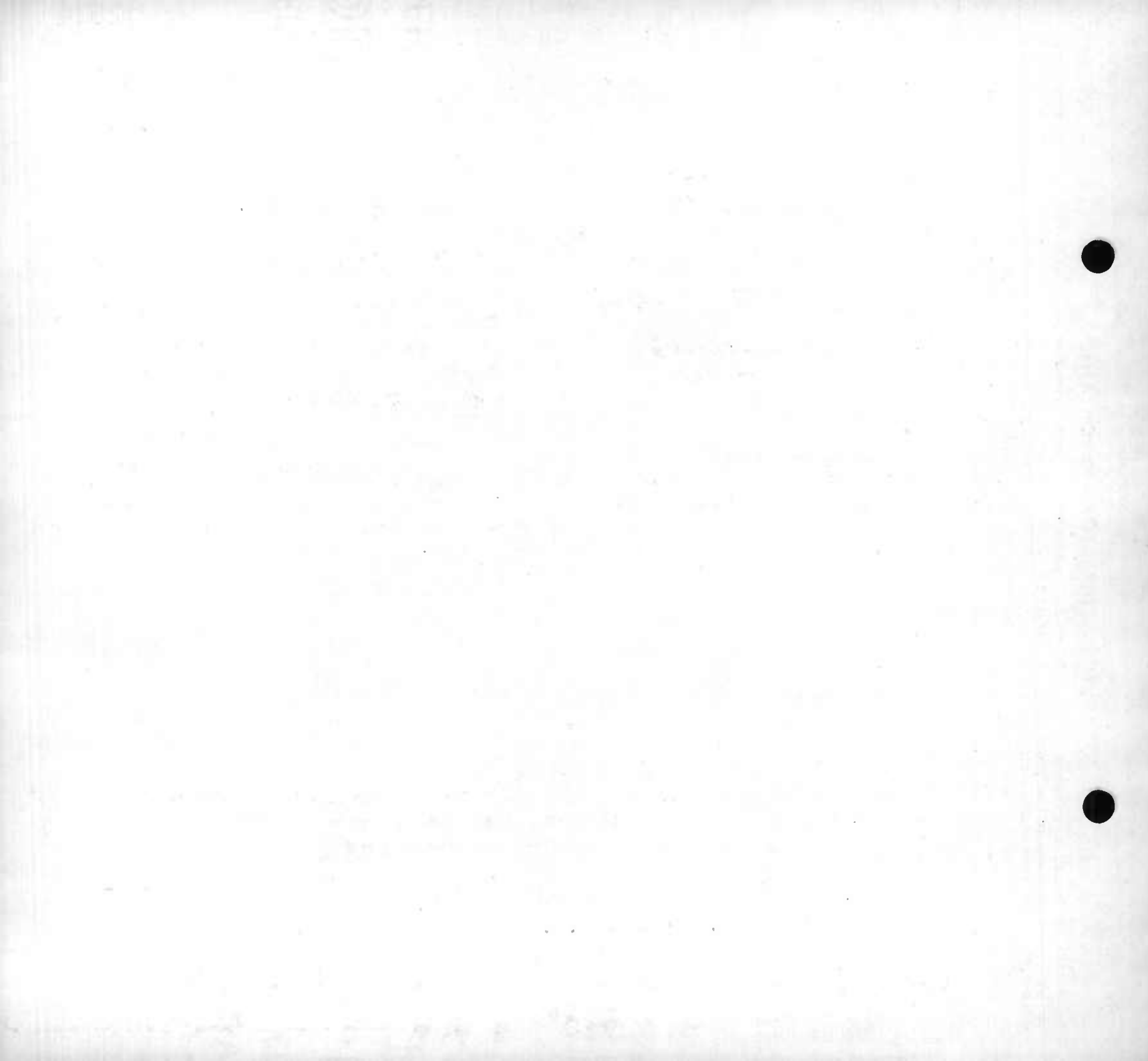
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 69 12923	
69 12923				CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		AMELIA THERESA BAXTER		12-25-69	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			A. STATE B. COUNTY		
00 413 N. MILTON AVE.			MARYLAND 602		
			C. CITY OR TOWN		D. INSIDE CITY LIMITS?
			BALTIMORE		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER		
			413 N. MILTON AVE.		
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years lost birthday)	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
F	W	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9-5-1889	90	HOUSEWIFE
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
		HOME		MARYLAND	U.S.A.
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
GEORGE MEYER			LAURA MEYER		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No		212038717D		Mr. Henri Siegel - 5150 Edmonson Ave.	
18. 431.91 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			CAUSE OF DEATH		
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		
ANTECEDENT CAUSES			Cerebral Hemorrhage		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			Arteriosclerotic Vascular Disease		
			(B) DUE TO, OR AS A CONSEQUENCE OF:		
			(C) DUE TO, OR AS A CONSEQUENCE OF:		
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
0				No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from Dec 12-1969 to Dec 25-1969, that (I) (we) last saw the deceased alive on Dec 24-1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
William G. Geyer				Dec-27-69	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
WILLIAM G. GEYER				156 N. Milton Ave	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
BURIAL		12-29-69		LODGEON PARK Cem.	
				BALTO., Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
DEC 30 1969		Robert E. Taylor, M.D.		Garth Miller - 2334 Jefferson St.	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 69 12924	
BIRTH NO. 69 12924		CERTIFICATE OF DEATH		X	
1. NAME OF DECEASED (Type or Print) ANNIE ELIZABETH MACK		2. DATE AND HOUR OF DEATH 12-28-69 7:30 P. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) HOUSE OF PINES-BELVEDERE 90 NURSING HOME.		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE MARYLAND B. COUNTY BALTO. CO. 5300 C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 803 RANGE COURT			
5. SEX F	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-16-1889	9. AGE (In years last birthday) 82	10. Under 1 Yr. Months: Days: 11. Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY HOME		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME JOHN HOFFMAN		14. MOTHER'S MAIDEN NAME AMELIA HAMILTON	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. -		17. INFORMANT ADDRESS Mr. Clifton Mack - 803 Range Court	
18. 412.31 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Pneumonia. (B) DUE TO, OR AS A CONSEQUENCE OF: Antecedent causes e.g. P. & embolism & Varicella virus. (C) -		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 days 6 mo.	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Nov 25 1969 to Dec 28 1969, that (I) (we) last saw the deceased alive on Dec 28 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Lester N. Kolman		23B. DATE SIGNED 12-30-69		23C. PHYSICIAN'S NAME (Type) LESTER N. KOLMAN, M.D.	
23D. ADDRESS 6821 Reisterstown Road		23E. DEGREE		23F. ATTENDING PHYS. Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>	
24A. BURIAL CREMATION, REMOVAL (Specify) ENTOMBMENT		24B. DATE 12-31-69		24C. NAME OF CEMETERY OR CREMATORY LORRAINE PARK CEM.	
24D. LOCATION BALTO., Mo.		24E. DATE REC'D BY HEALTH DEPT. DEC 30 1969		24F. NAME OF REGISTRAR Robert E. Taylor	
24G. FUNERAL DIRECTOR ADDRESS Hoffman's Funeral Home - 3218 Hudson St		24H. NAME OF REGISTRAR		24I. FUNERAL DIRECTOR	



69 12925

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

69 12925

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) <b>INELL LEVY</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year <b>December 25, 1969</b>		Hour <b>2:40 A. M.</b>
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>48 Maryland General Hospital</b>		3. DATE PRONOUNCED DEAD Month Day Year <b>December 25, 1969</b>		Hour <b>2:40 A. M.</b>
5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b>		B. COUNTY <b>1301</b>		
6. SEX <b>Female</b>	7. RACE <b>Negro</b>	B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Baltimore</b>
9. DATE OF BIRTH <b>April 5, 1927</b>		10. AGE (In years lost birthday) <b>42</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
11. BIRTHPLACE (State or foreign country) <b>Richmond, Virginia</b>		12. CITIZEN OF <b>U.S.A.</b>		E. STREET AND NUMBER <b>918 Whitelock Street</b>
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Waitress</b>		14B. KIND OF BUSINESS OR INDUSTRY		13. FATHER'S NAME <b>Harry Jones</b>
15. MOTHER'S MAIDEN NAME <b>Louise Minor</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>		
17. SOCIAL SECURITY NO.		18. INFORMANT <b>Marcellus Levy - 918 Whitelock St.</b>		
19. CAUSE OF DEATH <b>431.9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
20A. DATE OF OPERATION <b>2</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) <b>Yes</b>
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (if in Baltimore City, give exact location) INJURY OCCUR?
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>  ACTUAL SIGNATURE <b>Charles S. Springate, M.D.</b> CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) <b>Charles S. Springate, M.D.</b> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> <b>December 25, 1969</b>				
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>12-30-69</b>	24C. NAME OF CEMETERY or CREMATORY <b>Mt. Calvary</b>	24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 30 1969</b>	25B. NAME OF REGISTRAR <b>Robert E. Taylor, M.D.</b>	25C. FUNERAL DIRECTOR <b>Charles R. Law</b> ADDRESS <b>802 Madison Ave.</b>		

100-1000

100-1000

100-1000

100-1000

CHICAGO  
UNIVERSITY  
PHYSICS  
DEPARTMENT



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

69 12926

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO. 69 12926

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>HARRIS, BLANCHE KENT</b>		2. DATE AND HOUR OF DEATH <b>12-27-69 10:05 P.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MD</b> B. COUNTY <b>1501</b>	
FULL NAME OF HOSPITAL OR INSTITUTION <b>Lutheran Hospital of MD</b>				C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>46</b>				E. STREET AND NUMBER <b>1623 Vincent Ct.</b>	
5. SEX <b>F</b>	6. RACE <b>COLORED</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>10-12-1884</b>	9. AGE (In years last birthday) <b>85</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Bowling, Virginia</b>	
13. FATHER'S NAME <b>John Samuels</b>				14. MOTHER'S MAIDEN NAME <b>Mary L.</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>214-64-0309</b>		17. INFORMANT <b>Beatrice Edwards - 2106 Rupp St.</b>	
18. <b>427.0 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.) <b>Cong. Heart Failure</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b>				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:  (B) DUE TO, OR AS A CONSEQUENCE OF:  (C) _____	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). _____					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>-</b>		20A. AUTOPSY? (Yes or No) <b>-</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <b>-</b>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>-</b>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>-</b>	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <b>-</b>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <b>-</b>	
22. I certify that (I) (this hospital) attended the deceased from <b>12-15-1969</b> to <b>12-27-1969</b> , that (I) (we) last saw the deceased alive on <b>12-27-1969</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>KANTILAL J. SHAH M.D.</b>				23B. DATE SIGNED <b>12/27/69</b>	
23C. PHYSICIAN'S NAME (Type) <b>KANTILAL J. SHAH M.D.</b>				23D. ADDRESS <b>Lutheran Hospital</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12-31-69</b>		24C. NAME of CEMETERY or CREMATORY <b>Mt. Auburn</b>	
24D. LOCATION <b>Baltimore, Maryland</b>		(City, town, or county) (State)			
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 30 1969</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor, M.D.</b>		25C. FUNERAL DIRECTOR <b>Charles R. Law</b>	
				ADDRESS <b>802 Madison Ave.</b>	



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

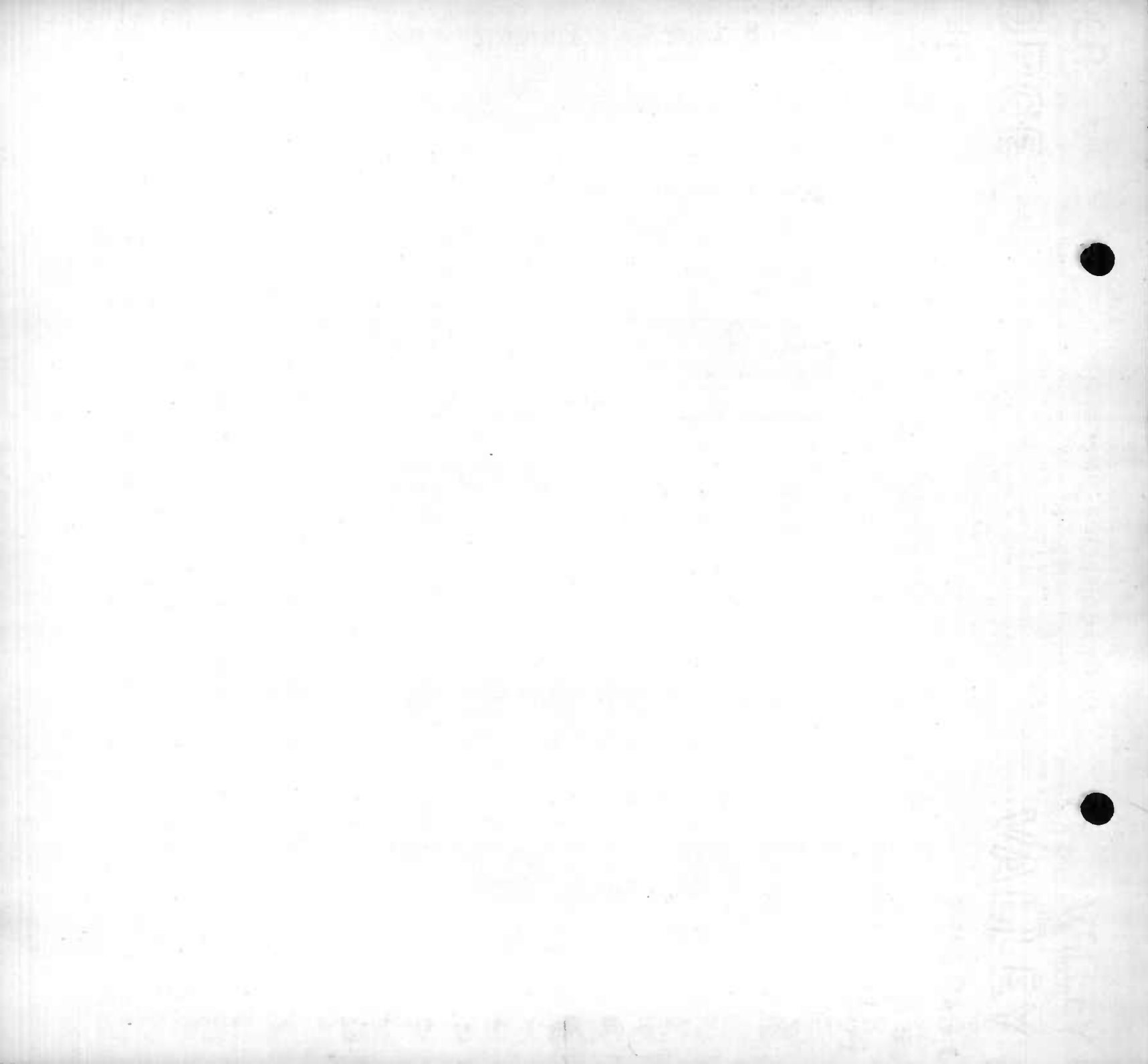
69 12927

**CERTIFICATE OF DEATH**

REG. NO.

69 12927

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>WARNER, MARION M.</b>		2. DATE AND HOUR OF DEATH <b>12-27-69 1:00 P. M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE _____ B. COUNTY _____			
FULL NAME OF HOSPITAL OR INSTITUTION <b>LUTHERAN HOSPITAL OF MARYLAND</b>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>46 LAND</b>		C. CITY OR TOWN <b>BAL. Md.</b>	
				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER <b>2810 ALLENDALE Rd.</b>			
5. SEX <b>F</b>	6. RACE <b>N</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>10-4-08</b>	9. AGE (In years lost birthday) <b>61</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Teacher</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>	
13. FATHER'S NAME <b>Ranmas A/ Matthews</b>		14. MOTHER'S MAIDEN NAME <b>Malinda Garner</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>214-40-4256</b>		17. INFORMANT <b>Mildred Matthews - 2810 Allendale Road</b>	
18. <b>573.9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>HEPATIC COMA.</b>		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
		(B) DUE TO, OR AS A CONSEQUENCE OF:			
		(C) DUE TO, OR AS A CONSEQUENCE OF:			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>12-26-1969</b> to <b>12-27-1969</b> , that (I) (we) lost saw the deceased alive on <b>12-27-69</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Violeta R Gamarra R.M.D.</b>				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) <b>VIOLETA R GAMARRA R.M.D.</b>				23D. ADDRESS <b>730 Ashburton St. Bal. Md</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12-31-69</b>		24C. NAME of CEMETERY or CREMATORY <b>Baltimore National</b>	
				24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 30 1969</b>		25B. NAME OF REGISTRAR <b>Charles R. Law</b>		25C. FUNERAL DIRECTOR ADDRESS <b>802 Madison Ave.</b>	



1  
J-525

69 12928

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

69 12928

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

DEBORAH BARNES JOHNSON

2. DATE  
OF  
DEATH

Known ☒ Estimated ☐

Month

Day

Year

Hour

December 24, 1969

M.

3. DATE  
PRONOUNCED DEAD

Month

Day

Year

Hour

December 24, 1969

8:50 P M.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

1801

6. SEX

Female

7. RACE

Negro

8. MARRIED ☐ NEVER MARRIED ☒

WIDOWED ☐ DIVORCED ☐

9. CITY OR TOWN

Baltimore

10. INSIDE CITY LIMITS?

YES ☒ NO ☐

9. DATE OF BIRTH

7-26-1962

10. AGE (In years last birthday)

7

11. If Under 1 Yr. II Under 24 Hrs. Months Days Hours Min.

12. STREET AND NUMBER

904 W. Lexington Street

11. BIRTHPLACE (State or foreign country)

Baltimore, Maryland

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Harold Barnes

14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Student

15. KIND OF BUSINESS OR INDUSTRY

16. MOTHER'S MAIDEN NAME

Mamie Johnson

16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

17. SOCIAL SECURITY NO.

18. INFORMANT

ADDRESS

Mamie J. Waugh - 904 W. Lexington St.

19.

E963X

CAUSE OF DEATH

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A) IMMEDIATE CAUSE

Strangulation

DUE TO, OR AS A CONSEQUENCE OF:

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).

MEDICAL CERTIFICATION

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

2

Yes

22A. EXTERNAL CAUSE WAS UNDERLYING ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.

22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

Home

22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

904 W. Lexington St.

22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

12-24-69

22E. INJURY OCCURRED

WHILE AT WORK ☐

NOT WHILE AT WORK ☒

22F. HOW DID INJURY OCCUR?

Strangulation

23.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐

ACTUAL SIGNATURE

Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☒

DATE SIGNED

ASSOCIATE MEDICAL EXAMINER ☐

December 25, 1969

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

12-29-69

24C. NAME OF CEMETERY or CREMATORY

Carver Memorial Park

24D. LOCATION (City, town, or county)

Laurel, Maryland

(State)

25A. DATE REC'D BY HEALTH DEPT.

DEC 30 1969

25B. NAME OF REGISTRAR

Robert E. J. [illegible]

25C. FUNERAL DIRECTOR

Charles R. Law 802 Madison Ave.

ADDRESS



1

T-300

69 12929

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 69 12929

BIRTH NO.		1. NAME OF DECEASED (Type or Print) James R. Tate		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> Month Day Year Hour	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 33 Hopkins Hospital		3. DATE PRONOUNCED DEAD 12 22 69 8:48 p.m.		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 802	
6. SEX male	7. RACE colordd	B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
9. DATE OF BIRTH July 31 1917	10. AGE (In years lost birthday) 52	11. BIRTHPLACE (State or foreign country) Maryland		E. STREET AND NUMBER 1829 N. Milton Ave.	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME James G. Tate		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer	
15. MOTHER'S MAIDEN NAME Eleanor Bruce		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.	
18. INFORMANT Thelma Tate		ADDRESS Same		19. 412.4 CAUSE OF DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		Arteriosclerotic cardiovascular disease (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) DUE TO, OR AS A CONSEQUENCE OF:			
(C) _____					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
20A. DATE OF OPERATION 0		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) no	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE: <u>Werner U. Spitz</u> M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) Werner U. Spitz, M.D. Deputy Chief Medical Examiner ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 12/23/69					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12-26-69		24C. NAME OF CEMETERY or CREMATORY Bretinwood National Cemetery	
24D. LOCATION (City, town, or county) (State) md.		25A. DATE REC'D BY HEALTH DEPT. DEC 30 1969		25B. NAME OF REGISTRAR Robert E. Fisher, R.D.	
25C. FUNERAL DIRECTOR Arlington S. Shields		ADDRESS 1727 N. Mount			



OFFICE OF THE SECRETARY OF THE ARMY  
WASHINGTON, D. C.

ACADEMY OF ARTS

OFFICE OF THE SECRETARY OF THE ARMY

1

THE SECRETARY OF THE ARMY  
WASHINGTON, D. C.

1890

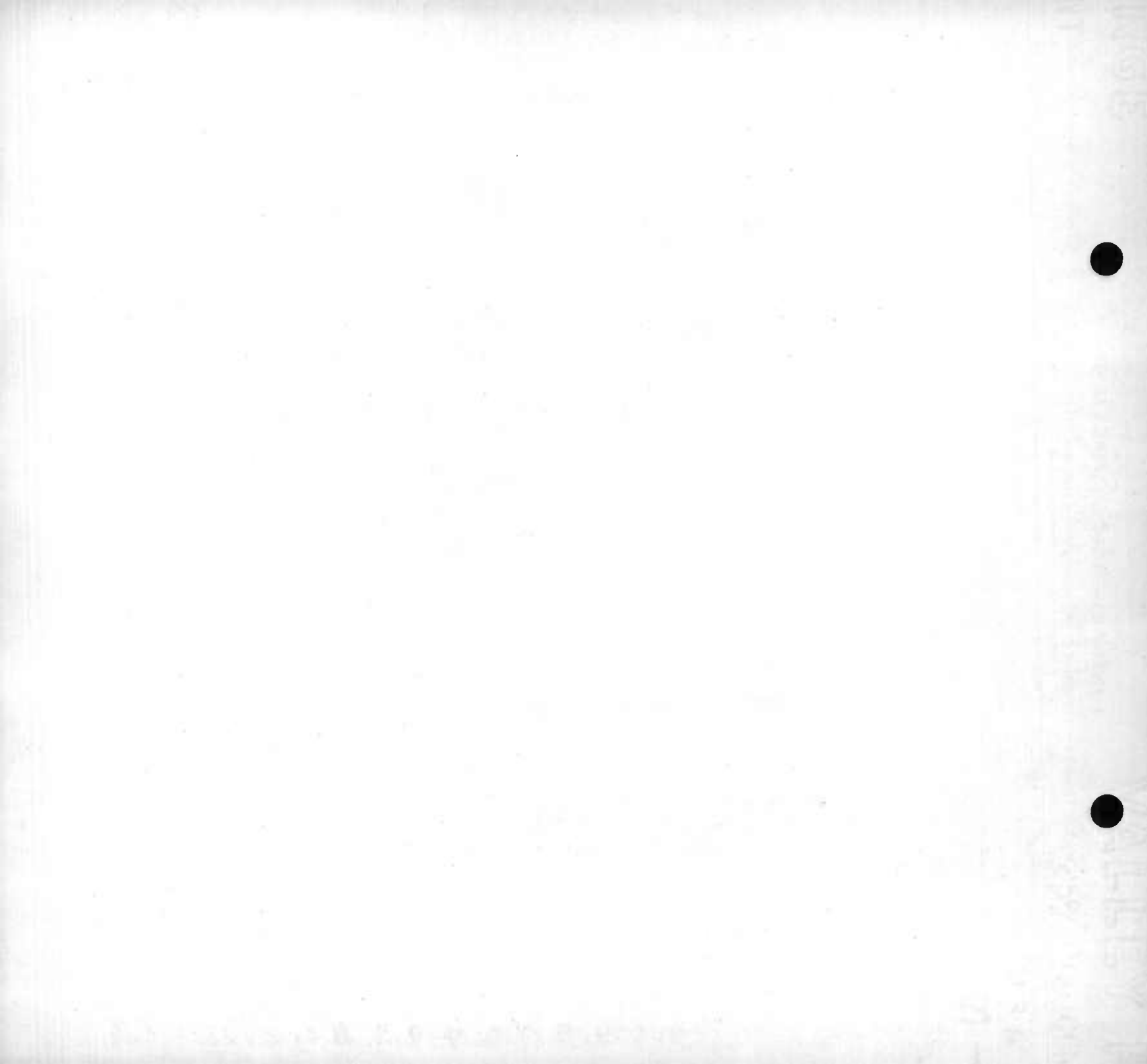
THE SECRETARY OF THE ARMY  
WASHINGTON, D. C.



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

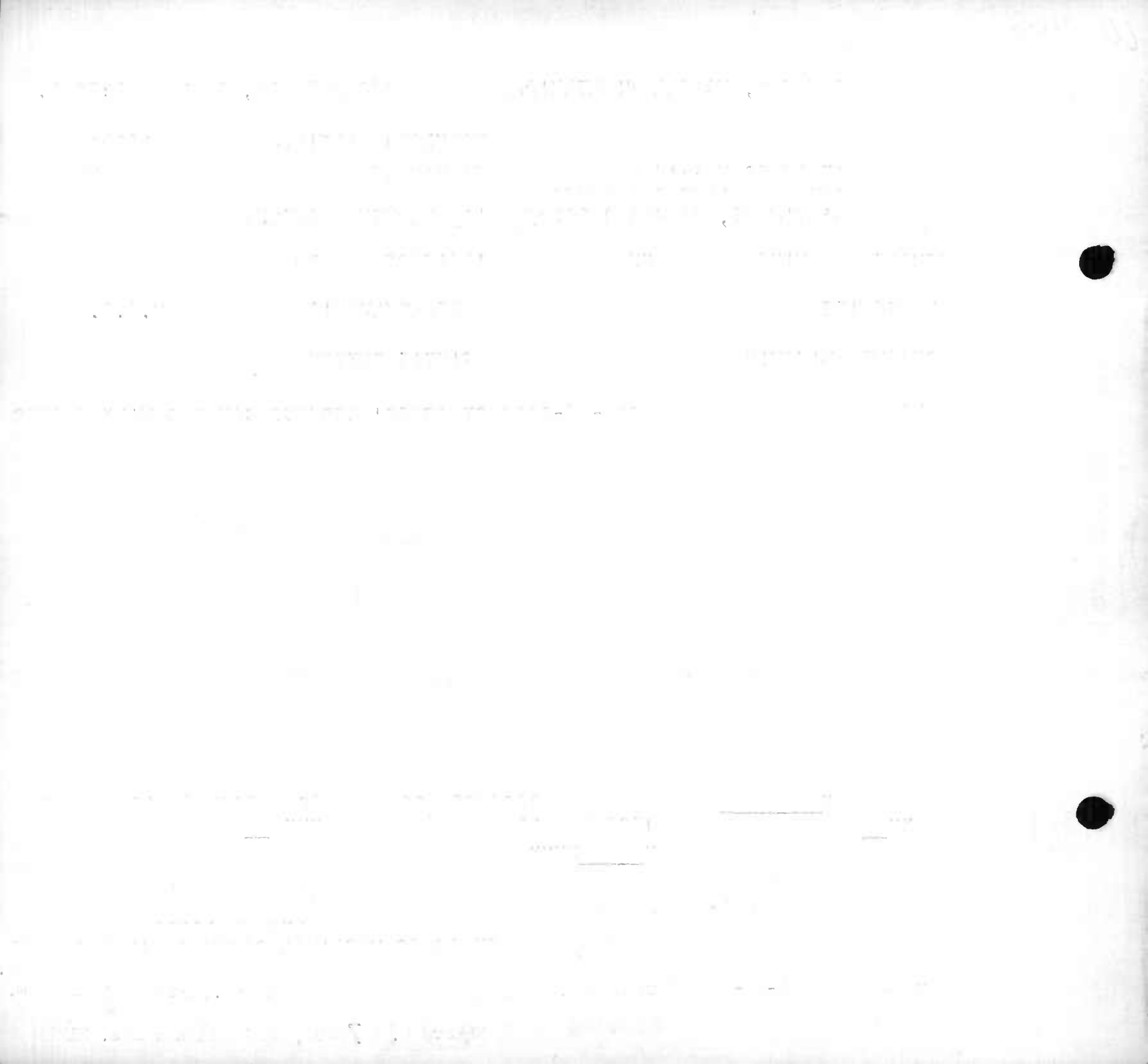
H-620		69 12930		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 69 12930	
1. NAME OF DECEASED (Type or Print) <b>HARRIS, Viola D.</b>				2. DATE AND HOUR OF DEATH <b>12/22/69 3:10 P. M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>Lutheran Hospital of Maryland, Inc.</b>				A. STATE <b>Md.</b>		B. COUNTY <b>Baltimore (21229)</b>	
				C. CITY OR TOWN		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 1608	
				E. STREET AND NUMBER <b>600 Grantley Street</b>			
5. SEX <b>F</b>	6. RACE <b>C</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>9-5-05</b>	9. AGE (In years last birthday) <b>64</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House wife</b>				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Alabama</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				13. FATHER'S NAME <b>Thomas Day Sr.</b>			
14. MOTHER'S MAIDEN NAME <b>Sara Glauer</b>				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. <b>419-58-16</b>				17. INFORMANT <b>Essie Gault</b>			
18. ADDRESS <b>Same</b>							
19. 237.6 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>H. Uraemia &amp; Cardiac Arrest.</b>				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Tumor of Bladder.</b>			
20. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b>				(B) DUE TO, OR AS A CONSEQUENCE OF: <b>(C) ...</b>			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>Yes.</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (this hospital) attended the deceased from <b>12-21-69</b> 19 to <b>12-22</b> 19 <b>69</b> , that (I) (we) last saw the deceased alive on <b>12-22</b> 19 <b>69</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Lajinder P. Gandhi</b>				23B. DATE SIGNED <b>12-22-69</b>			
23C. PHYSICIAN'S NAME (Type) <b>LAJINDER, P. G. ANDHI.</b>				23D. ADDRESS <b>730 ASHBURTON ST. BALTIMORE, MD. 21216.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <b>12-27-69</b>		24C. NAME of CEMETERY or CREMATORY <b>Arbutus Mem. Pl.</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 30 1969</b>		25B. NAME OF REGISTRAR <b>Robert E. Fisher, M.D.</b>		25C. FUNERAL DIRECTOR <b>Washington Phillips</b>		25D. ADDRESS <b>1727 M. Morse St.</b>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

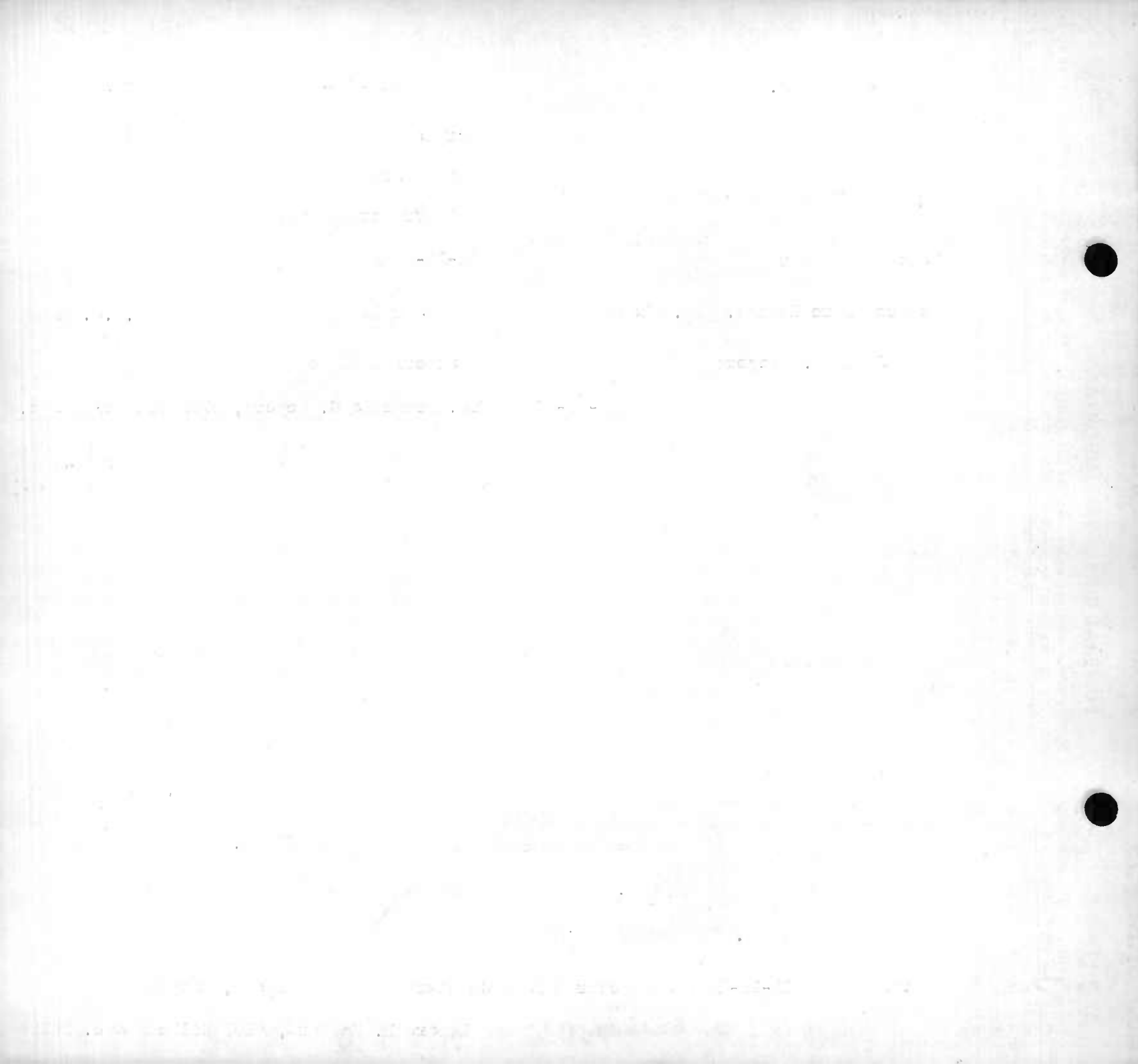
BALTIMORE CITY HEALTH DEPARTMENT				69 12931		REG. NO. 69 12931	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
		COMPTON, MABELL WILHELMIA		DECEMBER 27, 1969		2:30 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE		B. COUNTY	
40		ST AGNES HOSPITAL CATON & WILKENS AVENUES BALTIMORE, MARYLAND 21229		MARYLAND BALTIMORE		21228 5300	
5. SEX		6. RACE		C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
FEMALE		WHITE		BALTIMORE Catonsville		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		E. STREET AND NUMBER			
				419 MONTEMAR AVENUE			
8. DATE OF BIRTH		9. AGE (In years last birthday)		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country)	
12/15/90		79		HOUSEWIFE		PENNSYLVANIA	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY?			
				U.S.A.			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
STEPHEN HITCHIN				GITTIE SUTTON			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
NO		578-26-3110		ST AGNES' RECORDS CATON & WILKEN AVES			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE			
ANTECEDENT CAUSES				DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CH.F			
				A-S-C-V-D Personal State			
				(B) DUE TO, OR AS A CONSEQUENCE OF:			
				(C) DUE TO, OR AS A CONSEQUENCE OF:			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
				NO			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (X) (this hospital) attended the deceased from DECEMBER 22 19 69 to DECEMBER 27 19 69 that (X) (we) last saw the deceased alive on DECEMBER 27 19 69 and that (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
M. AFZAL M.D. DEGREE				12-27-69			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
M. AFZAL M.D. DEGREE				BALTO MD 21229 ST AGNES HOSPITAL CATON & WILKENS AVES			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		12-30-69		Fort Lincoln Mausoleum		Bladensburg Rd., Prince George Co. Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
DEC 30 1969		Robert E. Hubbard		Howard H. Hubbard		4107 Wilkens Ave. 21229	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

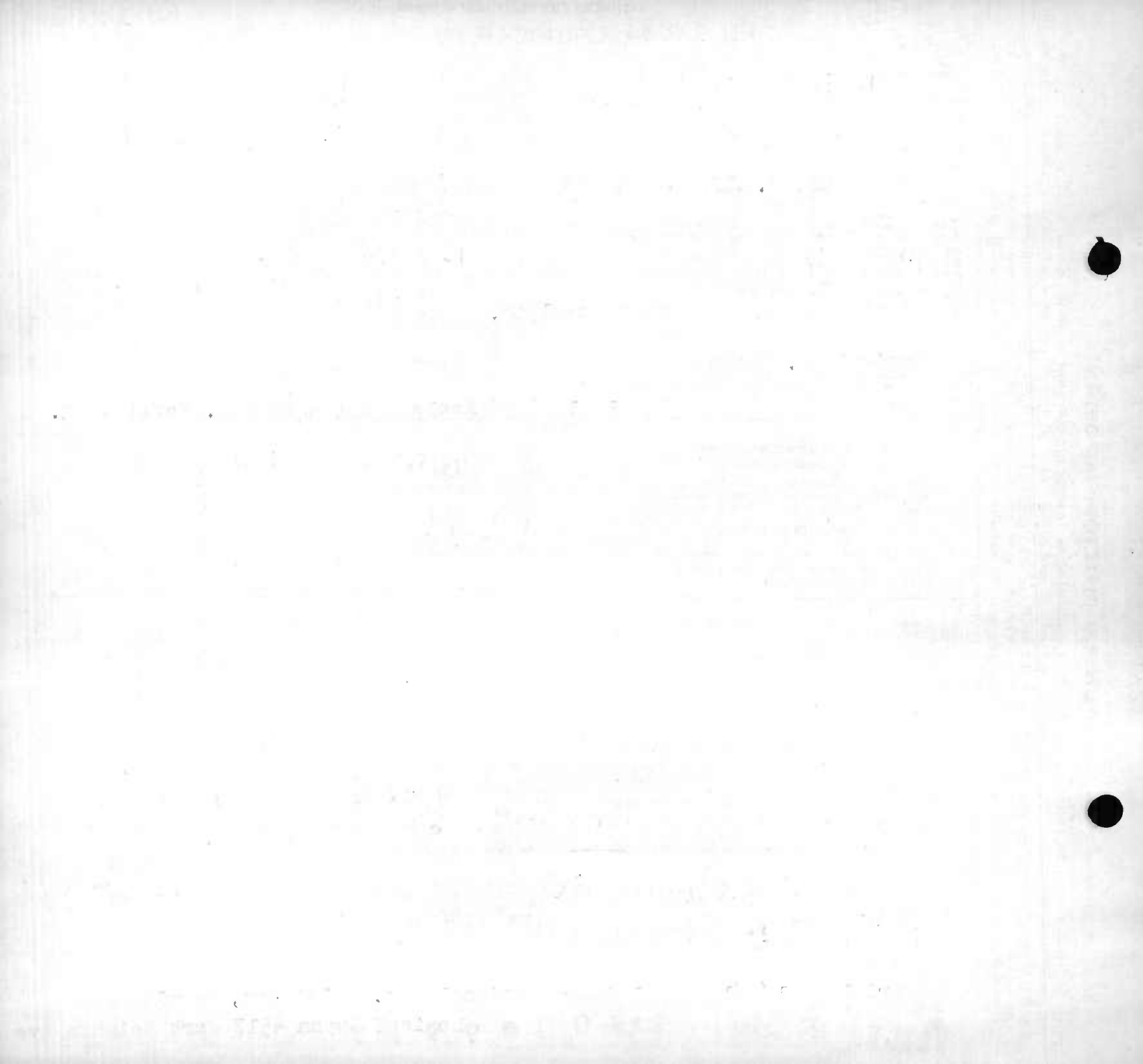
BALTIMORE CITY HEALTH DEPARTMENT						REG. NO. <u>69 12932</u>
BIRTH NO. <u>69 12932</u>						17-6201
1. NAME OF DECEASED (Type or Print) <u>John J. Meyers</u>			2. DATE AND HOUR OF DEATH <u>12-26-69</u> <u>1320</u> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>2854</u>			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>4708 Frederick Avenue</u>			C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
			E. STREET AND NUMBER <u>4708 Frederick Avenue</u>			
5. SEX <u>Male</u>	6. RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-26-1905</u>	9. AGE (In years last birthday) <u>64</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Fire Invest. Md. State</u>			11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John A. Meyers</u>			14. MOTHER'S MAIDEN NAME <u>Katherine Minke</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO. <u>214-05-4236</u>		17. INFORMANT <u>Mrs. Arthelia G. Meyers, 4708 Frederick Ave.</u>	
18. <u>472.4 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>A.C.V.H.D</u> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>	
MEDICAL CERTIFICATION						
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?		
22. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <u>2-3</u> <u>1961</u> to <u>12-26</u> <u>1969</u> , that (I) ( <del>we</del> ) last saw the deceased alive on <u>12-26</u> <u>1969</u> and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>we</del> ) (did) ( <del>did not</del> ) view the body after death. <u>Was at pts. home when he died.</u>						
23A. SIGNATURE <u>John F. Schaefer MD</u>		23B. DATE SIGNED <u>12/26/69</u>		23C. PHYSICIAN'S NAME (Type) <u>John F. Schaefer MD</u>		
23D. ADDRESS <u>401 Random Road</u>		24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>				
24B. DATE <u>12-29-1969</u>		24C. NAME OF CEMETERY or CREMATORY <u>S S Peter &amp; Paul Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Cumberland, Maryland</u>		
25A. DATE REC'D BY HEALTH DEPT. <u>DEC 30 1969</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>		25C. FUNERAL DIRECTOR <u>Howard H. Hubbard, 4107 Wilkens Ave. 21229</u>		



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

G-500		69 12933		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 69 12933	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) <b>ELIJAH ARKLES GWYNN</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				2. DATE AND HOUR OF DEATH <b>12/28/69 10 PM</b>			
FULL NAME OF HOSPITAL OR INSTITUTION <b>2508 W. FAYETTE STREET</b>				4. USUAL RESIDENCE (Where deceased lived; If institution; residence before admission) A. STATE <b>MD</b> B. COUNTY <b>Balto</b>			
C. CITY OR TOWN <b>Balto</b>				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
E. STREET AND NUMBER <b>2508 W Fayette Street</b>							
5. SEX <b>M</b>	6. RACE <b>N</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>12/30/16</b>		9. AGE (In years lost birthday) <b>52</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Steel</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Derby Steel Co.</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Benjamin B. Gwynn</b>				14. MOTHER'S MAIDEN NAME <b>Mary Cohen</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) Ill yes, give war or dates of service <b>no</b>		16. SOCIAL SECURITY NO. <b>216 10 5838</b>		17. INFORMANT <b>Mable E Gwynn 8508 W. Fayette St.</b>			
18. <b>410.9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>acute myocardial infarction</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>AFHD</b> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>4/22/68</b> to <b>12/28/69</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) <del>(we)</del> (did) (did not) view the body after death.							
23A. SIGNATURE <b>J. B. Ramirez MD</b>				23B. DATE SIGNED <b>12/30/69</b>		23C. PHYSICIAN'S NAME (Type) <b>J. B. RAMIREZ MD</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1/2/1970</b>		24C. NAME OF CEMETERY or CREMATORY <b>Baltimore National Cem.</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 30 1969</b>		25B. NAME OF REGISTRAR <b>Lewis T Gwynn</b>		25C. FUNERAL DIRECTOR ADDRESS <b>4517 Park Heights Ave</b>			





FUNERAL DIRECTOR: IMPORTANT

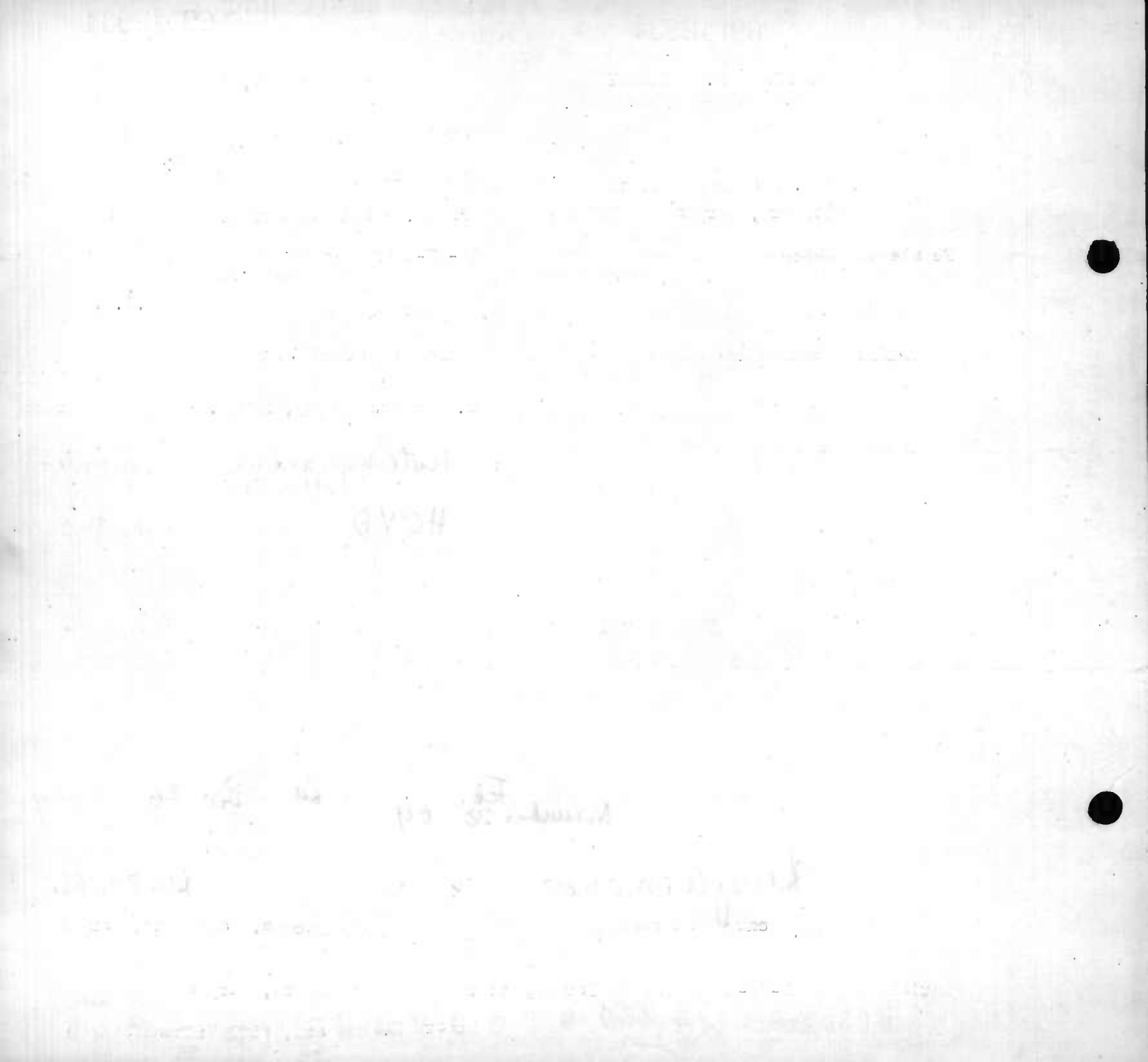
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

69 12934

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO. 69 12934

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>HAZEL M. CHANEY</b>		2. DATE AND HOUR OF DEATH <b>December 26, 1969</b>		M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>2005</b>			
FULL NAME OF HOSPITAL OR INSTITUTION <b>60</b>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>530 S. Smallwood Street Baltimore, Maryland 21223</b>		C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <b>Female</b>		6. RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>10-17-1905</b>	
9. AGE (In years last birthday) <b>64</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		11. BIRTHPLACE (State or foreign country) <b>Kentucky</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>James Winton Smith</b>				14. MOTHER'S MAIDEN NAME <b>Lielia Harlow Smith</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mr. Herbert Chaney, 530 S. Smallwood Street</b>		ADDRESS <b>21223</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>acute myocardial infarction</b> <b>HCVD</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>minutes</b> <b>months</b>			
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO, OR AS A CONSEQUENCE OF:		(C) DUE TO, OR AS A CONSEQUENCE OF:	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>Feb. 1969</b> to <b>Dec 26 1969</b> , that (I) (we) last saw the deceased alive on <b>November 28 1969</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Henry Armanas</b>				23B. DATE SIGNED <b>Dec 27, 1969</b>			
23C. PHYSICIAN'S NAME (Type) <b>Dr. Henry Armanas</b>		23D. ADDRESS <b>1934 Wilkens Avenue, Baltimore, Maryland</b>					
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12-29-1969</b>		24C. NAME OF CEMETERY or CREMATORY <b>Loudon Park Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 30 1969</b>		25B. NAME OF REGISTRAR <b>Robert S. Hubbard</b>		25C. FUNERAL DIRECTOR <b>Howard H. Hubbard</b>		ADDRESS <b>21229</b> <b>4107 Wilkens Avenue</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

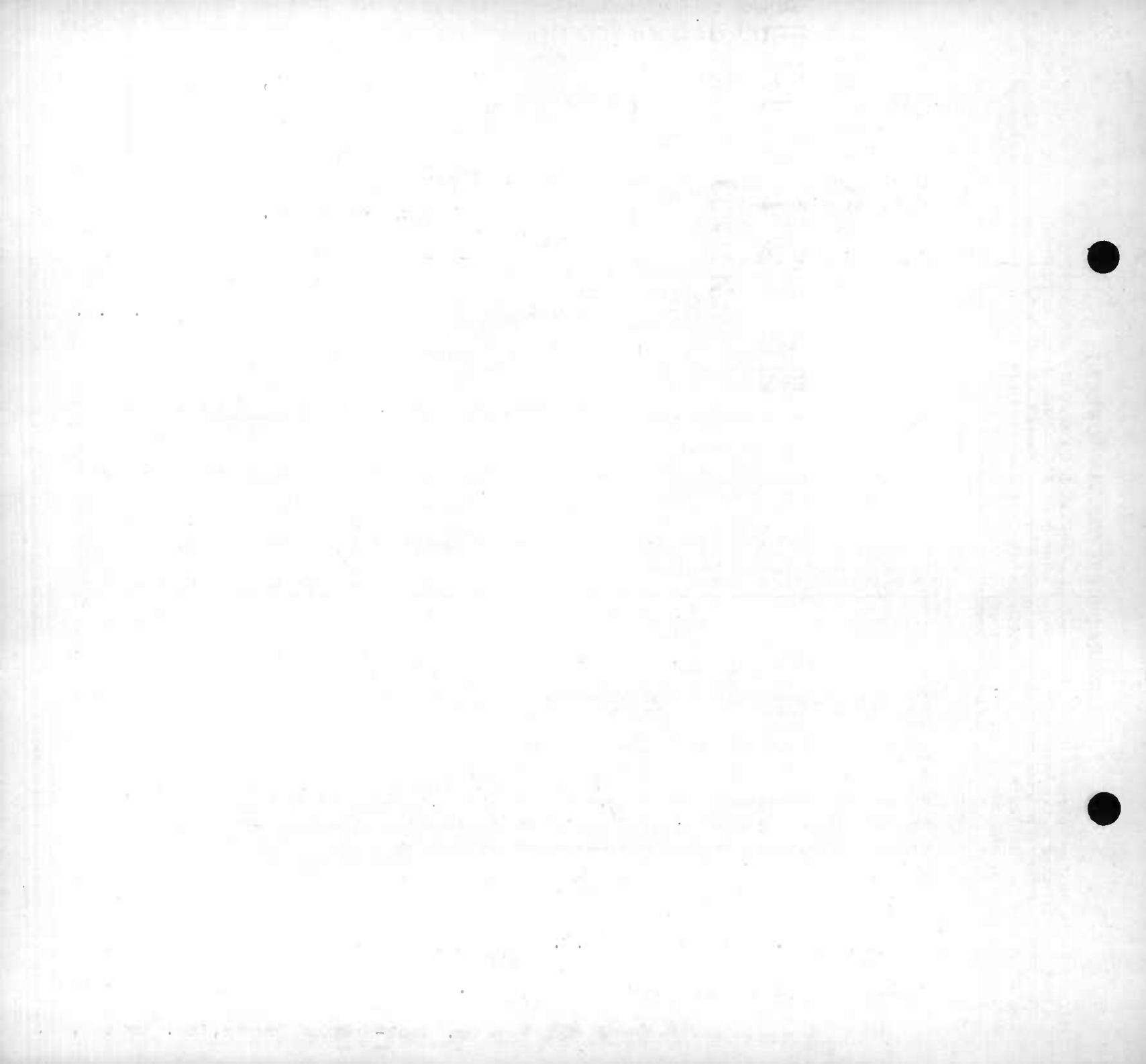
BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO.	
69 12935		69 12935		69 12935	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
BROOKS, NORA Ellsworth		12/25 1969 16.00 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE B. COUNTY			
UNION MEMORIAL HOSPITAL 44		Md BALTIMORE 2749			
5. SEX		6. RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	
FEMALE		WHITE		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH	
HOUSE WIFE		OWN home		02/22-1896	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		9. AGE (In years last birthday)	
MARYLAND		U.S.A.		73	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		11. CITY OR TOWN	
JAMES KRAMER		JANKOWA Theresa Thorn		BALTIMORE	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT	
NO		71		MR. HERBERT M. ALLEN	
18. CAUSE OF DEATH		19. MEDICAL CERTIFICATION		ADDRESS	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		119 MARGATE RD LUTHERVILLE, MD.	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			
CEREBROVASCULAR ACCIDENT		ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE			
- PROBABLY EMOLISM		+ ATRIAL FIBRILLATION			
DUE TO, OR AS A CONSEQUENCE OF:		DUE TO, OR AS A CONSEQUENCE OF:			
		PNEUMONIA OF THE LEFT LUNGS			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
0				NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (1) (this hospital) attended the deceased from NOVEMBER 18 1969 to DECEMBER 25 1969 that (1) (we) last saw the deceased alive on DECEMBER 25, 530AM '69 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE		23B. DATE SIGNED			
J. Paul Mikus		12/25-69			
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
J. PAUL MIKUS		UNION MEMORIAL HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		12-29-69		OAK LAWN CEMETERY	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
DEC 30 1969		Robert E. J. J. J.		J. M. COOK - BROOKS TOWSON INC.	
				ADDRESS 1050 YORK RD TOWSON, MD.	



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

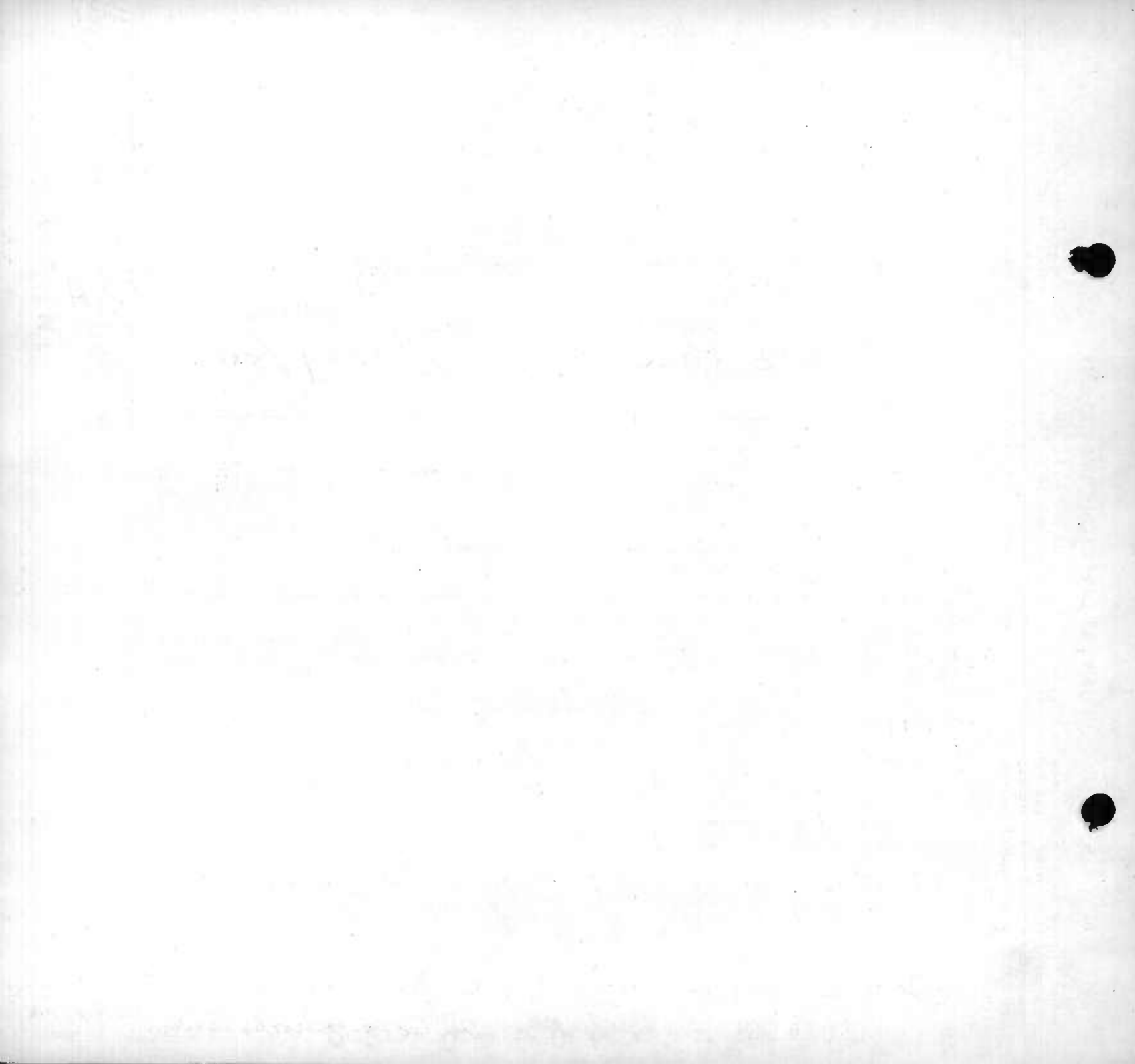
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 69 12936
BIRTH NO. 69 12936		<b>CERTIFICATE OF DEATH</b>		
1. NAME OF DECEASED (Type or Print) <b>THURSTON HALL GOODWIN</b>		2. DATE AND HOUR OF DEATH <b>December 25, 1969 8:40 A.M.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b>		
FULL NAME OF HOSPITAL OR INSTITUTION <b>Gould Nursing Home</b> <b>6711 Belair Road</b>		C. CITY OR TOWN <b>Parkville</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
5. SEX <b>Male</b> 6. RACE <b>Caucasian</b>		E. STREET AND NUMBER <b>8760 Lackawanna Ave.</b>		
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. AGE (In years last birthday) <b>85</b>		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Fireman</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Baltimore City Fire Department</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME <b>Ruby Allison</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>220-44-1048</b>		17. INFORMANT <b>Raymond A. Goodwin</b> ADDRESS <b>Same as # 4 E</b>
18. <b>412.4 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Arteriosclerotic C-V disease</b> <b>Pulmonary edema</b> <b>Senility</b>		CAUSE OF DEATH DUE TO, OR AS A CONSEQUENCE OF: (B) <b>Senility</b> (C) _____		
19. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <b>Nov. 25, 1969</b> to <b>Dec. 25, 1969</b> , that (I) ( <del>we</del> ) last saw the deceased alive on <b>Dec. 24, 1969</b> and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>we</del> ) ( <del>did not</del> ) view the body after death.				
23A. SIGNATURE <b>H. V. Harbold M.D.</b>		23B. DATE SIGNED <b>Dec. 26, 1969</b>		23C. PHYSICIAN'S NAME (Type) <b>Harold V. Harbold</b> M.D. DEGREE
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12-29-69</b>		24C. NAME OF CEMETERY or CREMATORY <b>Dulaney Valley Mem. Gardens</b>
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 30 1969</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor, M.D.</b>		25C. FUNERAL DIRECTOR <b>Wm. Cook &amp; Brooks</b> ADDRESS <b>Towson, Inc. Towson, Md.</b>



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				REG. NO. 69 12937	
BIRTH NO. 69 12937		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>SAMUEL PAUL</b>		2. DATE AND HOUR OF DEATH <b>12-25-1969 2:30 P.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MD.</b> B. COUNTY <b>BALTIMORE</b>			
FULL NAME OF HOSPITAL OR INSTITUTION <b>SOUTH BALTIMORE GEN. HOSPITAL</b>		C. CITY OR TOWN <b>BALTO</b>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <b>119 E. Keegan St.</b>					
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12-17-1891</b>	9. AGE (In years last birthday) <b>78</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Penna</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>					
13. FATHER'S NAME <b>JACOB PAUL</b>		14. MOTHER'S MAIDEN NAME <b>Nancy Reed</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>EDWARD CONRAD</b>	
18. <b>441.21</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Myocardial Infarction</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Arteriosclerotic Heart Disease</b>		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Abdominal Aneurysm</b>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>12-25-1969</b> to <b>12-25-1969</b> , that (I) (we) lost saw the deceased alive on <b>12-25-1969</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>MARCELINO E. SOROGOR</b>		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>12-26-1969</b>	
23C. PHYSICIAN'S NAME (Type) <b>MARCELINO E. SOROGOR</b>		23D. ADDRESS <b>SOUTH BALTO. GEN. HOSPITAL</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>12/29/69</b>	24C. NAME OF CEMETERY or CREMATORY <b>Northumberland Mem</b>		24D. LOCATION (City, town, or county) (State) <b>Northumberland Co. Penna</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 30 1969</b>		25B. NAME OF REGISTRAR <b>Philip E. Fisher</b>		25C. FUNERAL DIRECTOR <b>Wm. Cook - Brooks Town</b>	





5-530

## BALTIMORE CITY HEALTH DEPARTMENT

69 12938 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

69 12938

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) <b>GEORGE E. SMITH, Jr.</b>		2. DATE OF DEATH Known <input type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year <b>12 26 69</b>		Hour <b>8:05 a.</b>
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>St. Agnes Hospital D.O.A.</b>		3. DATE PRONOUNCED DEAD Month Day Year <b>December 26, 1969</b>		Hour <b>8:05 a.</b>
5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b>		B. COUNTY <b>1205</b>		
6. SEX <b>Male</b>	7. RACE <b>White</b>	B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Balto.</b>
9. DATE OF BIRTH <b>April 12, 1912</b>		10. AGE (In years last birthday) <b>58 57</b>		E. STREET AND NUMBER <b>1809 St. Paul St.</b>
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF <b>U.S.A.</b>		13. FATHER'S NAME <b>George Edward Smith, Sr.</b>
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY		15. MOTHER'S MAIDEN NAME <b>Unknown</b>
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO. <b>213 12 3911</b>		18. INFORMANT <b>Howard Smith, Route 4, Frederick, Maryland</b>
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Arteriosclerotic cardiovascular disease</b> DUE TO, OR AS A CONSEQUENCE OF: DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
20A. DATE OF OPERATION <b>2</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) <b>YES</b>
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <b>Ronald N. Kornblum</b> M.D. EXAMINER'S NAME (Type) <b>Ronald N. Kornblum, M.D.</b> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>12/27/69</b>				
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12/29/1969</b>		24C. NAME OF CEMETERY or CREMATORY <b>Resthaven Memorial Gardens</b>
24D. LOCATION (City, town, or county) (State) <b>Hansonville Frederick Md.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>DEC 30 1969</b>		
25B. NAME OF REGISTRAR <b>Ronald E. Taylor, M.D.</b>		25C. FUNERAL DIRECTOR <b>M. R. Etchison &amp; Son, Frederick, Md.</b>		

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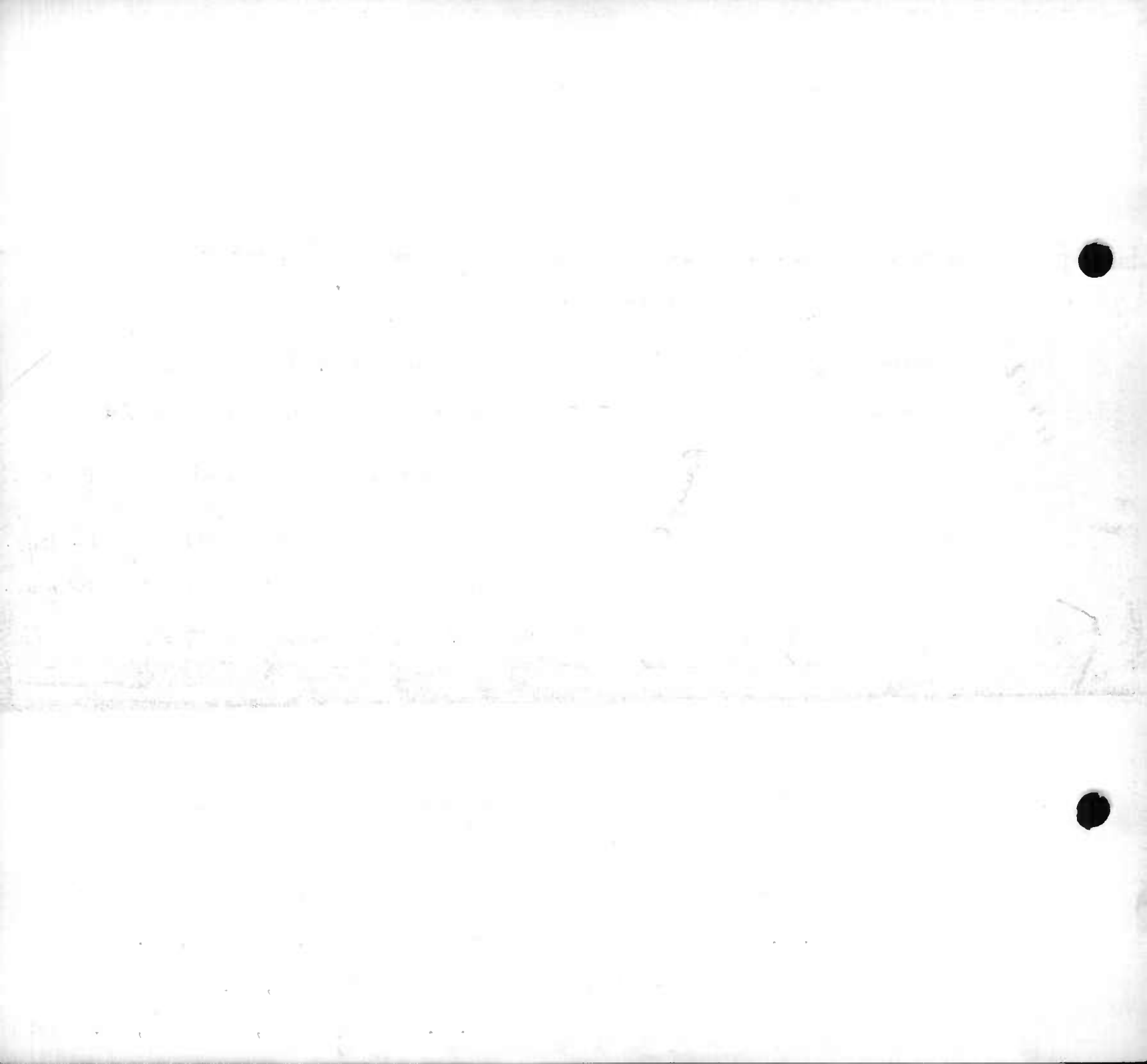
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ALC/ALP/ELM/ELD/ELP

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

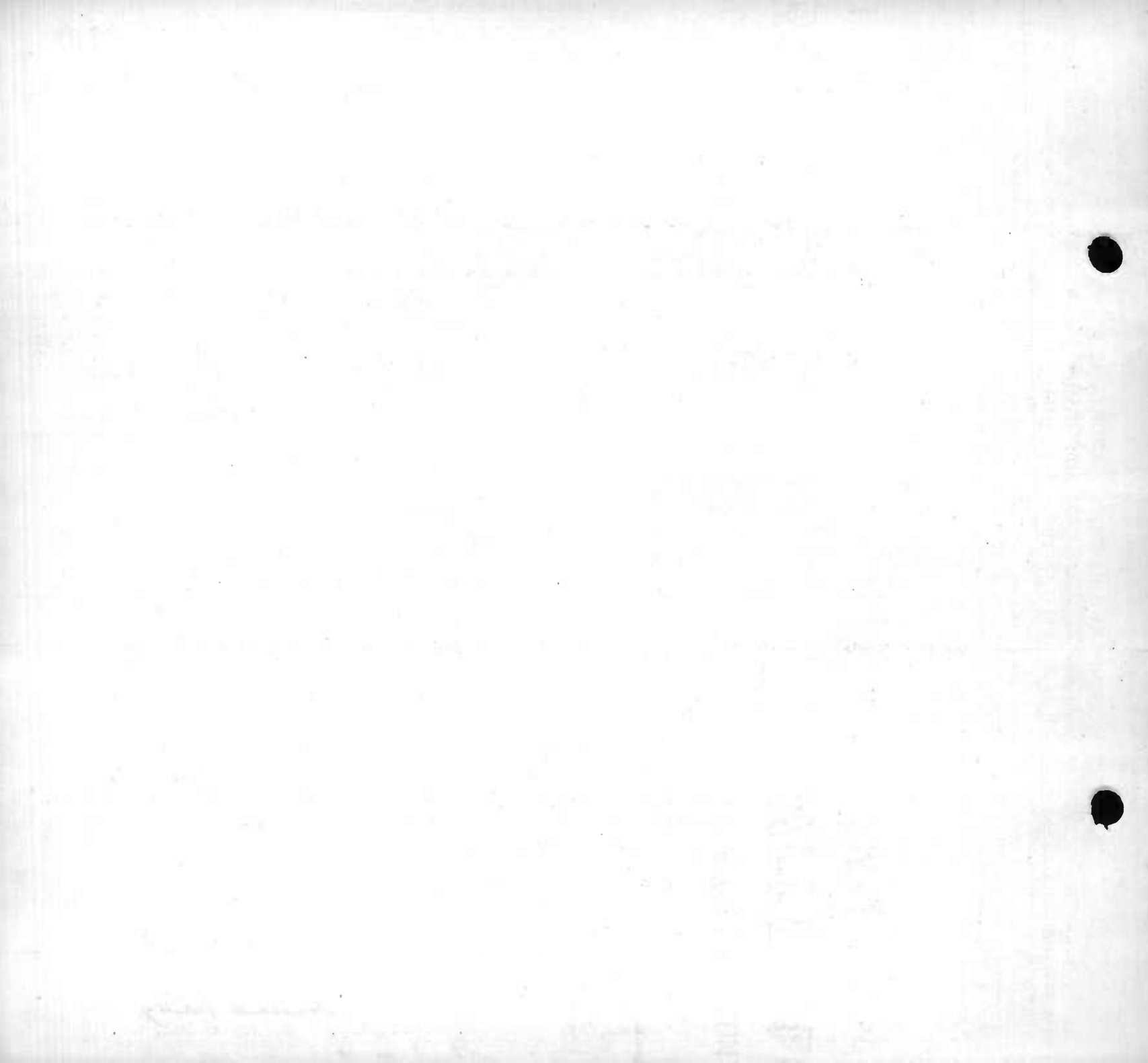
BALTIMORE CITY HEALTH DEPARTMENT				X		REG. NO. <u>69 12939</u>	
69 12939				CERTIFICATE OF DEATH			
BIRTH NO.				2. DATE AND HOUR OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>JOHN W. THOMPSON</u>				12/26/69 112.20 p.m.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>UNIVERSITY OF MARYLAND HOSPITAL</u>				A. STATE <u>MD.</u> ANNE ARUNDEL 5200			
IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION				B. COUNTY			
				C. CITY OR TOWN <u>Box 183 SEVERN</u>			
				D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
				E. STREET AND NUMBER <u>RT #1, Box 183 SEVERN Md.</u>			
5. SEX <u>MALE</u>		6. RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH <u>6/20/07</u>	
				WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. AGE (in years last birthday) <u>62</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>CARPENTER</u>		<u>Construction</u>		<u>Md.</u>		<u>U.S.</u>	
13. FATHER'S NAME <u>JOHN F. THOMPSON</u>				14. MOTHER'S MAIDEN NAME <u>MARY V. KISSMAUL</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service <u>Unknown</u> NO				16. SOCIAL SECURITY NO. <u>214-10-2484</u>		17. INFORMANT ADDRESS	
				<u>WIFE - NAOMI THOMPSON</u>			
18. <u>412.41</u> CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				<u>PULMONARY EMBOLUS</u> 10 days			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES				<u>ATRIAL FIBRILLATION</u> 14 days			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO, OR AS A CONSEQUENCE OF:			
				(C) <u>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</u> 10 years			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				<u>CHRONIC OBSTRUCTIVE AIRWAY DISEASE</u>			
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
(APPROX.)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from <u>12/22/1969</u> to <u>12/26/1969</u> that (I) (we) last saw the deceased alive on <u>12/26/1969</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>A. M. Dayle</u>				23B. DATE SIGNED <u>12/26/69</u>			
23C. PHYSICIAN'S NAME (Type) <u>A. M. Dayle</u>				23D. ADDRESS <u>University Hospital, Baltimore, Md.</u>			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>12/30/69</u>		<u>Mount Olivet Cemetery</u>		<u>Frederick, Md. 21701</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>DEC 30 1969</u>		25B. NAME OF REGISTRAR <u>Robert E. Taber, M.D.</u>		25C. FUNERAL DIRECTOR <u>Frank A. Smith Jr.</u>		25D. ADDRESS <u>M. R. Etchison &amp; Son, Frederick, Md. 21701</u>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <u>69 12940</u>				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <u>135-18-58</u>	
1. NAME OF DECEASED (Type or Print) <u>JANET FROST</u>				2. DATE AND HOUR OF DEATH <u>12/28/69</u> <u>4 51</u> P. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MD</u> B. COUNTY <u>FREDERICK</u>			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>33</u> <u>JOHNS HOPKINS HOSP</u>				C. CITY OR TOWN <u>FREDERICK</u>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
				E. STREET AND NUMBER <u>439 CARROLLTON DR</u>			
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7/29/68</u>		9. AGE (In years last birthday) <u>17</u> MO	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) *****			10B. KIND OF BUSINESS OR INDUSTRY *****		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>HARRY FROST</u>				14. MOTHER'S MAIDEN NAME <u>BARBARA Knepp</u> <u>(SAME)</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>PARENTS</u>			
18. <u>183.01</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>PNEUMONIA &amp; ATELECTASIS</u> (B) <u>MASSIVE ASCITES</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>METASTATIC SARCOMA OF (L) OVARY</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>48 hrs</u> <u>10 days</u> <u>3 months</u>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>Yes</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>12/22</u> 19 <u>69</u> to <u>12/28</u> 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>12/28</u> 19 <u>69</u> and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated above, (I) <u>did</u> (did not) <u>view</u> the body after death.							
23A. SIGNATURE <u>Joseph T Coyle MD</u>				23B. DATE SIGNED <u>12/28/69</u>		23C. PHYSICIAN'S NAME (Type) <u>JOSEPH T COYLE MD</u>	
23D. ADDRESS <u>JOHNS HOPKINS HOSPITAL</u>							
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	24B. DATE <u>12/30/69</u>	24C. NAME OF CEMETERY or CREMATORY <u>Sunset Memorial Park</u>		24D. LOCATION (City, town, or county) (State) <u>Nr. Cumberland Garrett Md.</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>DEC 30 1969</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor MD</u>		25C. FUNERAL DIRECTOR <u>Donald W. Fidelity</u> ADDRESS <u>M. R. Etchison &amp; Son Frederick, Md.</u>			



## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 69 12941				BALTIMORE CITY HEALTH DEPARTMENT		X		REG. NO. 69 12941	
1. NAME OF DECEASED (Type or Print) Snyder, George D.				2. DATE AND HOUR OF DEATH 12-29-69 12:40 A.M.					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY Balto. 5300					
FULL NAME OF HOSPITAL OR INSTITUTION 31 (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224				C. CITY OR TOWN Dundalk		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
5. SEX Male				6. RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH 12-21-98				9. AGE (in years lost birthday) 71		10. UNDER 1 Yr. Months Days Hours Min. If Under 24 Hrs. Min.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired - Bartender				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland			
12. CITIZEN OF WHAT COUNTRY? USA				13. FATHER'S NAME James T. Snyder					
14. MOTHER'S MAIDEN NAME Louise ?				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No					
16. SOCIAL SECURITY NO. 217-01-3084				17. INFORMANT ADDRESS 4940 Eastern Avenue BCH Records: Baltimore, Maryland 21224					
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). Congestive Heart Failure, Tension Pneumothorax				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 20 years +					
19A. DATE OF OPERATION 3/2/19				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Respiratory Insufficiency		20A. AUTOPSY? (Yes or No) YES			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) No				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (1) (this hospital) attended the deceased from 12/16/69 to 12/29/69 that (1) (we) last saw the deceased alive on 12/28/69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.				23A. SIGNATURE Edward J. Lee M.D. 23B. DATE SIGNED 12/29/69					
23C. PHYSICIAN'S NAME (Type) EDWARD J. LEE M.D.				23D. ADDRESS BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE BALTIMORE, MARYLAND 21224					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial				24B. DATE 12/31/69		24C. NAME OF CEMETERY OR CREMATORY Moreland Memorial Park			
24D. LOCATION Baltimore, Maryland				25A. DATE REC'D BY HEALTH DEPT. DEC 30 1969					
25B. NAME OF REGISTRAR Robert E. Taylor M.D.				25C. FUNERAL DIRECTOR John J. Duda					
25D. ADDRESS 7922 Wise Ave. Dundalk, Md.									

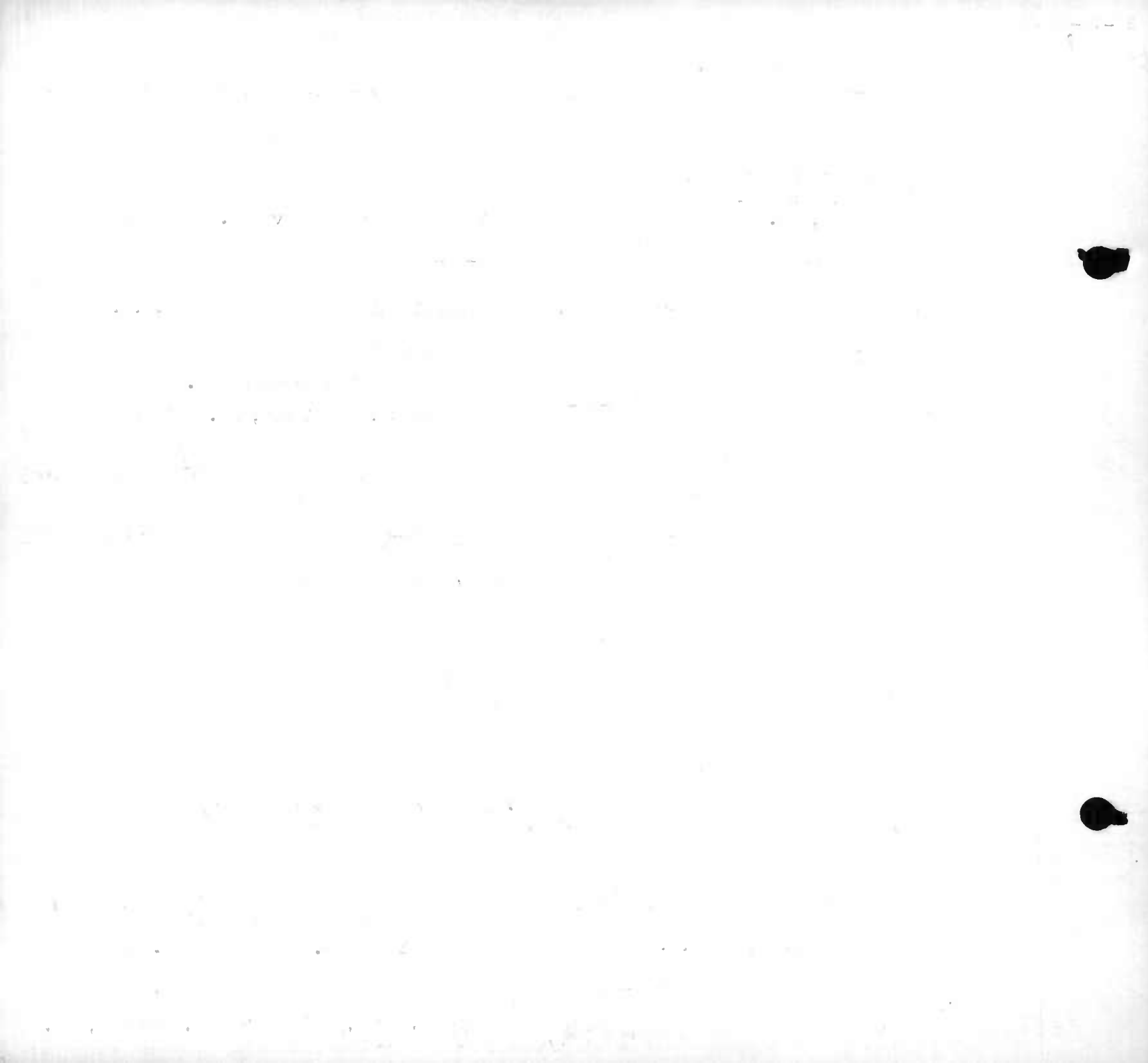




This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

FUNERAL DIRECTOR: IMPORTANT

BALTIMORE CITY HEALTH DEPARTMENT				X REG. NO. 69 12942	
BIRTH NO. 69 12942				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) George R. Lund		2. DATE AND HOUR OF DEATH 12/27/69 7:07 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY Baltimore			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Baltimore City Hospitals 4940 Eastern Ave. Baltimore, Md. 21224		C. CITY OR TOWN Dundalk		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX Male		6. RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Welder		10B. KIND OF BUSINESS OR INDUSTRY Anchor Post Co.		8. DATE OF BIRTH 6-22-09	
13. FATHER'S NAME Samuel Lund		14. MOTHER'S MAIDEN NAME Sarah		9. AGE (In years lost birthday) 60	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 095-01-9152		17. INFORMANT 4940 Eastern Ave. ADDRESS BCH Records: Baltimore, Md. 21224	
18. 436.01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: respiratory arrest		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH ~ 3 hours	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) CVA DUE TO, OR AS A CONSEQUENCE OF:		~ 10 hours	
(C) hypertension					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 12/27 19 69 to 12/27/69 19 that (I) (we) last saw the deceased alive on 12/27 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Dale Henken M.D.				23B. DATE SIGNED 12/27/69	
23C. PHYSICIAN'S NAME (Type) Dale Henken M.D.				23D. ADDRESS Baltimore City Hospitals 4940 Eastern Ave. Baltimore Md. 21224	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/31/69		24C. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery	
25A. DATE REC'D BY HEALTH DEPT. DEC 30 1969		25B. NAME OF REGISTRAR John E. Fisher M.D.		25C. FUNERAL DIRECTOR 7922 Wise Ave. Dundalk, Md.	
24D. LOCATION (City, town, or county) Baltimore, Maryland					



56-04-18 db1

69 12943

BALTIMORE CITY HEALTH DEPARTMENT

## CERTIFICATE OF DEATH

REG. NO.

69 12943

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

George C. Boyer, Jr.

2. DATE AND HOUR OF DEATH

12-27-1969 10:00 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

BALTIMORE CITY HOSPITALS

4940 Eastern Avenue

Baltimore, Maryland 21224

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland, Baltimore

C. CITY OR TOWN

Edgemere

D. INSIDE CITY LIMITS?

YES ☐NO ☒

E. STREET AND NUMBER

7304 Gephardt Lane 21219 005

5. SEX

Male

6. RACE

White

7. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

8. DATE OF BIRTH

8-25-12

9. AGE (In years  
last birthday)

57

If Under 1 Yr.  
Months DaysIf Under 24 Hrs.  
Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Shipping Clerk

10B. KIND OF BUSINESS OR INDUSTRY

Air Reductions Co.

11. BIRTHPLACE (State or foreign country)

South Dakota

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

George C. Boyer, Sr.

14. MOTHER'S MAIDEN NAME

Jean Storey

15. Was Deceased Ever in U. S. Armed Forces?

(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

212-12-2633

17. INFORMANT

BCH-Records

ADDRESS

4940 Eastern Avenue

Baltimore, Maryland 21224

18. 441.31

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, osteoporosis, etc. It means the disease,  
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving  
rise to the above cause (A) stating the  
UNDERLYING CONDITION last.RUPTURED ABDOM -  
WAL AORTIC ANEURYSM 10 H.

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART I (A).

19A. DATE OF OPERATION

12-27-69

19B. CONDITION FOR WHICH OPERATION

WAS PERFORMED

RUPTURED ANEURYSM

20A. AUTOPSY? (Yes or No)

NO

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING ☐  
OR CONTRIBUTING ☐ CAUSE OF  
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg,  
etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At ☐  
WorkNot While ☐  
At Work

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 12-27 1969 to 12-27 1969,  
that (I) (we) last saw the deceased alive on 12-27 1969 and that in (my) (our) opinion death occurred on the date  
and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

William E. Powers, Jr. MD

Attending  
Phys. ☐Med.  
Director ☐Staff  
Phys. ☒

23B. DATE SIGNED

12-27-69

23C. PHYSICIAN'S  
NAME (Type)

William E. Powers, Jr. MD

23D. ADDRESS

BCH

4940 Eastern Avenue

Baltimore, Maryland 21224

24A. BURIAL CREMATION,  
REMOVAL (Specify)

Cremation

24B. DATE

12/30/69

24C. NAME of CEMETERY or CREMATORY

Greenmount Crematory

24D. LOCATION

(City, town, or county)

Baltimore, Maryland

(State)

25A. DATE REC'D BY HEALTH DEPT.

DEC 30 1969

25B. NAME OF REGISTRAR

R. J. Duda

25C. FUNERAL DIRECTOR

John J. Duda

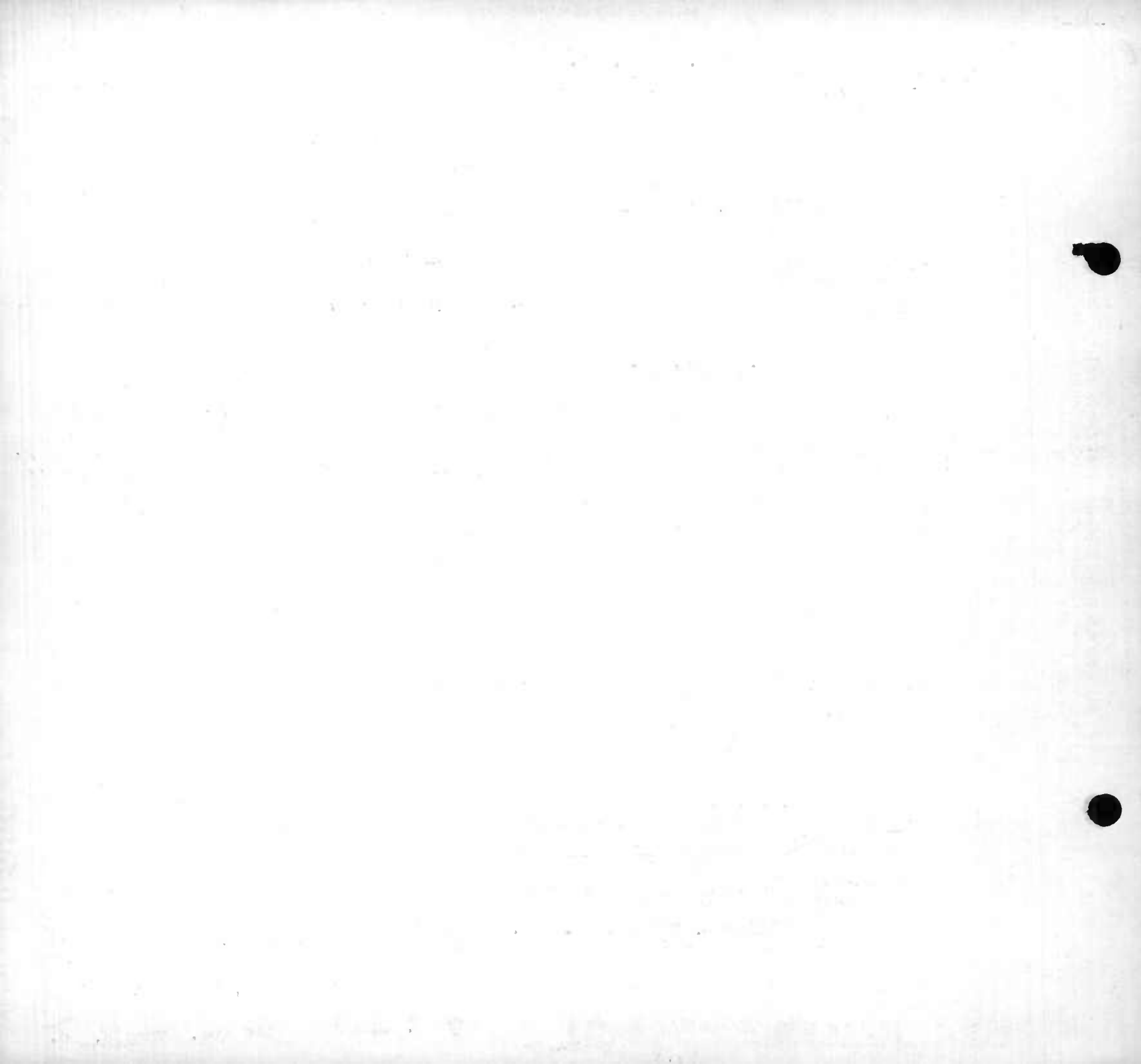
ADDRESS

7922 Wise Ave. Dundalk, Md.

21222

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

## MEDICAL CERTIFICATION

BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <b>69 12944</b>	
69 12944		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <b>Bertha J. Ferg</b> <b>BERTHA FERG</b>		2. DATE AND HOUR OF DEATH <b>12-26-68</b> <b>8-15 P.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>35 Church Home &amp; Hospital</b> <b>CHURCH HOME HOSPITAL</b>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MD</b> B. COUNTY <b>Baltimore</b> C. CITY OR TOWN <b>Edgemere</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER <b>2634 Brannan Avenue</b>	
5. SEX <b>Female</b>	6. RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>February 15, 1896</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years Birthdays) <b>73</b>
11. BIRTHPLACE (State or foreign country) <b>GERMANY</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Edward Oleznoi</b> <b>EDWARD OLCZNOI</b>		14. MOTHER'S MAIDEN NAME <b>Julia</b>	
15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>196-07-6733-D</b>	
17. INFORMANT Son: <b>EDWARD FERG</b>		ADDRESS <b>Balto. Md. 21234 KILDAIRE AVE</b>	
18. <b>410.91</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b> <b>(A) IMMEDIATE CAUSE CARDIAC FAILURE</b> <b>DUE TO, OR AS A CONSEQUENCE OF:</b> <b>(B) MESENTERIC THROMBOSIS</b> <b>DUE TO, OR AS A CONSEQUENCE OF:</b> <b>(C) MYOCARDIAL INFARCTION - EMBOLUS</b> <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION <b>0</b>	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) <b>No</b>	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>12-20-68</b> 19 to <b>12-26-1968</b> that (I) (we) last saw the deceased alive on <b>19</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <b>[Signature]</b>		23B. DATE SIGNED <b>12/26/68</b>	
23C. PHYSICIAN'S NAME (Type) <b>CARLOS A. LEA PLAZA</b>		23D. ADDRESS <b>5518 D JARRIL RD. 21206 BALTO.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>12/29/68</b>	24C. NAME OF CEMETERY or CREMATORY <b>Meadowridge Memorial Park</b>	24D. LOCATION (City, town, or county) (State) <b>Dorsey, Maryland</b>
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 30 1968</b>		25B. NAME OF REGISTRAR <b>Robert E. Tabor, M.D.</b>	25C. FUNERAL DIRECTOR <b>John J. Duda</b> ADDRESS <b>7922 Wise Ave. Dundalk, Md. 21222</b>



E-430

## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

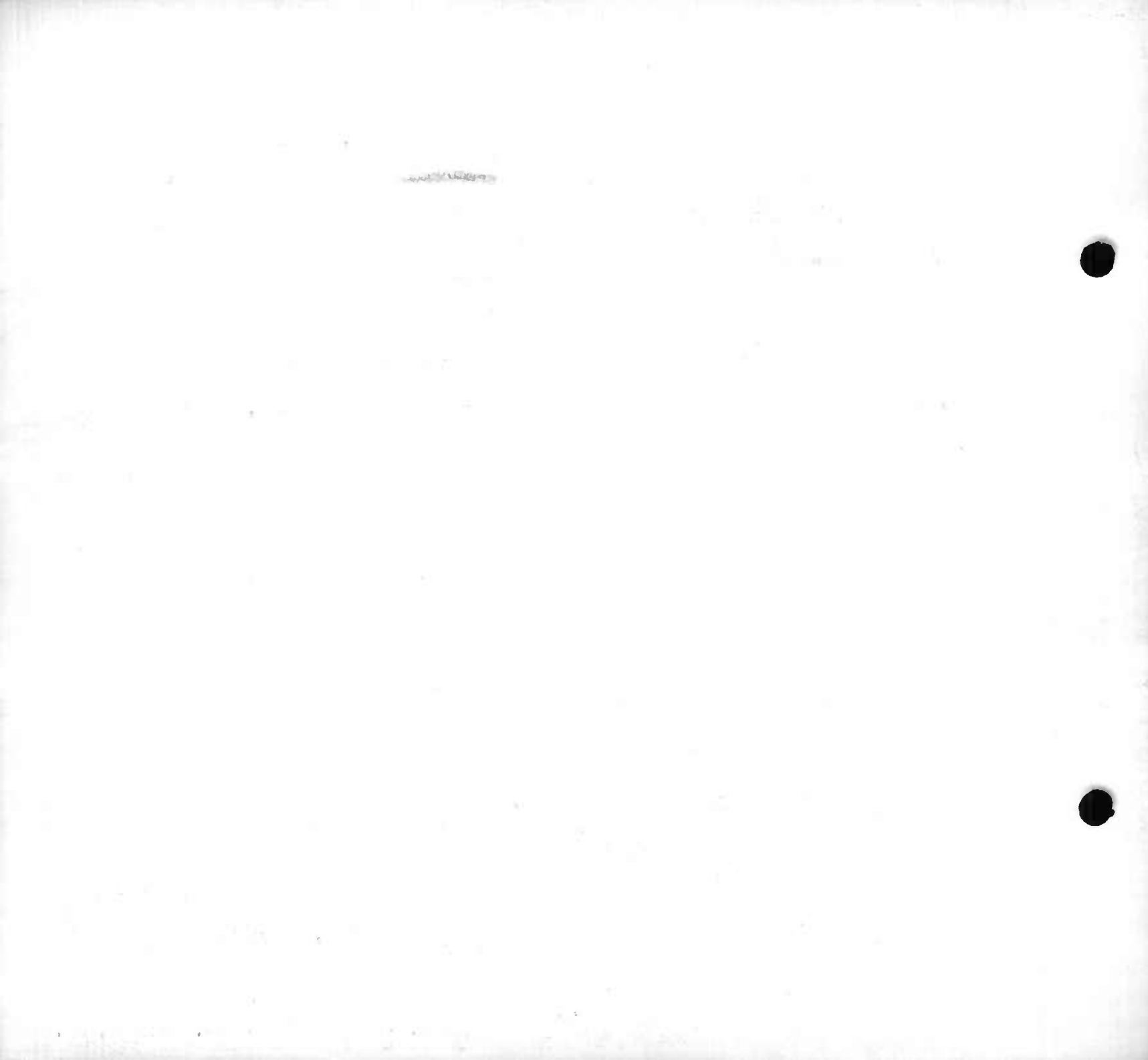
BALTIMORE CITY HEALTH DEPARTMENT

## CERTIFICATE OF DEATH

REG. NO.

69 12945

BIRTH NO. 69-23519 69 12945		1. NAME OF DECEASED (Type or Print) George Elliott		2. DATE AND HOUR OF DEATH 12-27-69 7:43 a M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE B. COUNTY		5300	
FULL NAME OF HOSPITAL OR INSTITUTION		IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION		Dundalk	
BALTIMORE CITY HOSPITAL 4940 Eastern Avenue Baltimore, Maryland 21224		E. STREET AND NUMBER		8031 WALLACE RD 21222 005	
5. SEX Male	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/22/69	9. AGE (In years lost birthday) 5	10. Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND	
13. FATHER'S NAME Thomas Hollen		14. MOTHER'S MAIDEN NAME Patricia Elliott		12. CITIZEN OF WHAT COUNTRY USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. None		17. INFORMANT ADDRESS BCH-Records 4940 Eastern Avenue Baltimore, Maryland 21224	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: anoxia, acidosis		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 18 hours	
ANTECEDENT CAUSES (DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.)		(B) heart failure		2 days	
		(C) congenital malformation (B)		?	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Dec. 22 1969 to December 27 1969 that (I) (we) last saw the deceased alive on December 27 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) did (did not) view the body after death.					
23A. SIGNATURE B.F. Petit		23B. DATE SIGNED 12/27/69		23C. PHYSICIAN'S NAME (Type) B.F. Petit	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/29/69		24C. NAME of CEMETERY or CREMATORY Oak Lawn	
25A. DATE REC'D BY HEALTH DEPT. DEC 30 1969		25B. NAME OF REGISTRAR R. B. E. Taylor		25C. FUNERAL DIRECTOR John J. Duda	
				ADDRESS 7922 Wise Ave. Dundalk, Md. 21222	





55-98-93 TB  
6-260

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

**FUNERAL DIRECTOR: IMPORTANT**

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>Rudolf J. Geiser sr.</u>		2. DATE AND HOUR OF DEATH <u>12/17/69</u> <u>3:50</u> <u>4</u> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE <u>Pennsylvania</u> B. COUNTY <u>V-35</u>	
FULL NAME OF HOSPITAL OR INSTITUTION <u>31</u>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Baltimore City Hospital</u> <u>4940 Eastern Avenue</u> <u>Baltimore, Maryland 21224</u>		C. CITY OR TOWN <u>Levittown</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <u>30 Pebble Lane</u>		<u>19054</u>			
5. SEX <u>Male</u>	6. RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/29/10</u>	9. AGE (In years last birthday) <u>59</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Army</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>U. S. Govt</u>		11. BIRTHPLACE (State or foreign country) <u>Austria</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Anton Geiser</u>			
14. MOTHER'S MAIDEN NAME <u>Rosa Felner</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>Yes</u> <u>1944-1969</u>			
16. SOCIAL SECURITY NO. <u>182-10-4469</u>		17. INFORMANT ADDRESS <u>Records: BCH-4940 Eastern Avenue 21224</u>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <u>4/10/9</u>		CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>Cardiac Arrest</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>MI</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>ASCVD</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>50 min.</u> <u>4 hrs.</u> <u>~10 yrs</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>12/17</u> 19 <u>69</u> to <u>12/17</u> 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>12/17</u> 19 <u>69</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Jack D. McCue M.D.</u>				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) <u>Jack D. McCue</u>		23D. ADDRESS <u>Baltimore City Hospital</u> <u>4940 Eastern Avenue Balto., Md. 21224</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>12/20/69</u>		24C. NAME OF CEMETERY or CREMATORY <u>Northwood Cem</u>	
24D. LOCATION <u>Philadelphia Pa</u>		24E. (City, town, or county) (State)			
25A. DATE REC'D BY HEALTH DEPT. <u>DEC 30 1969</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>		25C. FUNERAL DIRECTOR <u>Robert J. Benancio, Levittown, Pa</u>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Bodily burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

F-623 69 12947		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 69 12947	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Forestell, Mr. James D.		12-29-69 3:45 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		MD		903	
Maryland General Hospital		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER 3706 Delverme RD			
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years lost birthday)	10. CITIZEN OF WHAT COUNTRY?
M	W		6-15-1898	71	MD. U.S.A.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Retired - SIGNORE STEEL CO.				MD.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME			
James E. Forestell		ANASTACIA A. (Agnes) Mc Guire			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No		213-01-7192		Jos. D. Brown 5800 Glenbrook Ct.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
		Pulmonary Congestion & Edema		Days	
ANTECEDENT CAUSES		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
		Portal cirrhosis, nutritional type		Years	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF:			
		Lymphoma Splenomegaly			
		(C) DUE TO, OR AS A CONSEQUENCE OF:			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
2				Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
				Yes	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (this hospital) attended the deceased from 12-18-1969 to 12-29-1969, that (I) last saw the deceased alive on 12-29-1969 and that in (our) opinion death occurred on the date and hour and from the causes stated above. (I) (did) (did not) view the body after death.					
23A. SIGNATURE		23B. DATE SIGNED			
J. S. Kim M.D.		12-29-69			
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
J. S. Kim M.D.		Maryland General Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		1/2/1970		New Cathedral	
				Baltimore Md.	
25A. DATE RECD. BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
DEC 30 1969		H.W. Jenkins & Sons Co.		4905 York Rd. Balto, Md. 21212	

Patented September 18, 1902  
Patent Office, Washington, D.C.

yes

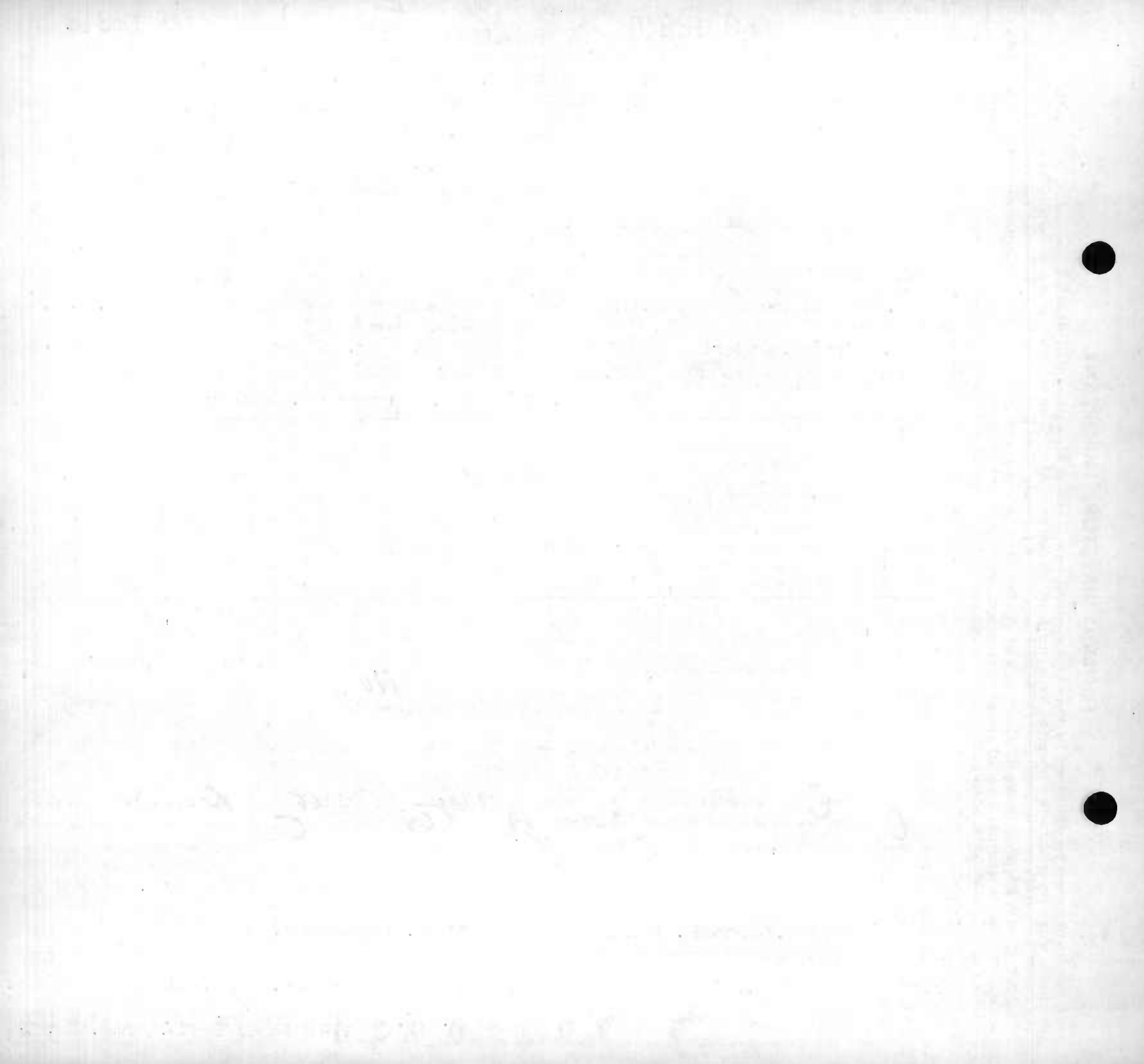
X

2.2 KLM W.D.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <b>69 12948</b>	
H-163		69 12948		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
Charles Wagner Hoppert Sr.		Dec. 26, 1969		4 P. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION  00 5513 The Alameda		A. STATE Maryland			
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER 5513 The Alameda			
5. SEX M	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-7-1909	9. AGE (In years last birthday) 60	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret'd. Communication		10B. KIND OF BUSINESS OR INDUSTRY Dept. Balto. City Fire		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME C. Elmer Hoppert		14. MOTHER'S MAIDEN NAME Nina M. McComb	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 163-05-9557		17. INFORMANT Mrs. Charles W. Hoppert	
18. 410.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Myocardial infarction</i> (B) <i>Arteriosclerotic Heart Disease</i> (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>5 minutes</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <i>Scrotal Abscess Non speaking.</i>					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from <i>May</i> 19 <i>66</i> to <i>Dec. 26</i> 19 <i>69</i> , that (1) (we) lost saw the deceased alive on <i>Nov. 19</i> 19 <i>69</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>John S. Haines</i>				23B. DATE SIGNED 12/29/69	
23C. PHYSICIAN'S NAME (Type) Dr. John S. Haines				23D. ADDRESS 11 E. Chase Street	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12-30-1969		24C. NAME of CEMETERY or CREMATORY Gardens of Faith	
24D. LOCATION (City, town, or county) (State) Baltimore, County, Md.					
25A. DATE REC'D BY HEALTH DEPT. DEC 30 1969		25B. NAME OF REGISTRAR <i>Robert E. Taylor</i>		25C. FUNERAL DIRECTOR H. W. Jenkins & Sons Co.	
ADDRESS 4905 York Road Balto., Md. 21212					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT  
69 12949 CERTIFICATE OF DEATH

REG. NO. 69 12949

S-616

BIRTH NO. 1

1. NAME OF DECEASED (Type or Print) **Laura R. Schriber**

2. DATE AND HOUR OF DEATH **12/26/69 1:20 P.M.**

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE **Maryland** B. COUNTY **Baltimore City** **1102**

5. SEX **F** 6. RACE **W** 7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH **8/14/88** 9. AGE (In years last birthday) **81** If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **Housewife** 10B. KIND OF BUSINESS OR INDUSTRY **Own Home** 11. BIRTHPLACE (State or foreign country) **Pennsylvania** 12. CITIZEN OF WHAT COUNTRY? **USA**

13. FATHER'S NAME **John Hannon** 14. MOTHER'S MAIDEN NAME **Rose McCool**

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) **No** 16. SOCIAL SECURITY NO. **214-20-3464** 17. INFORMANT **Mrs. C. Louis Rein** ADDRESS **4300 N. Chas. St.**

18. **412.1 I** CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE **Renal failure** DUE TO, OR AS A CONSEQUENCE OF: **2 months**

(B) **arteriosclerotic nephrosclerosis** DUE TO, OR AS A CONSEQUENCE OF: **yes**

(C) **generalized arteriosclerosis** **yes**

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). **Arteriosclerotic heart disease** **yes**

19A. DATE OF OPERATION **2** 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED **yes** 20A. AUTOPSY? (Yes or No) **yes** 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)

21E. INJURY OCCURRED While At ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from **Nov. 11** 19 **69** to **Dec. 26** 19 **69**, that (I) (we) lost saw the deceased alive on **Dec. 26** 19 **69** and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

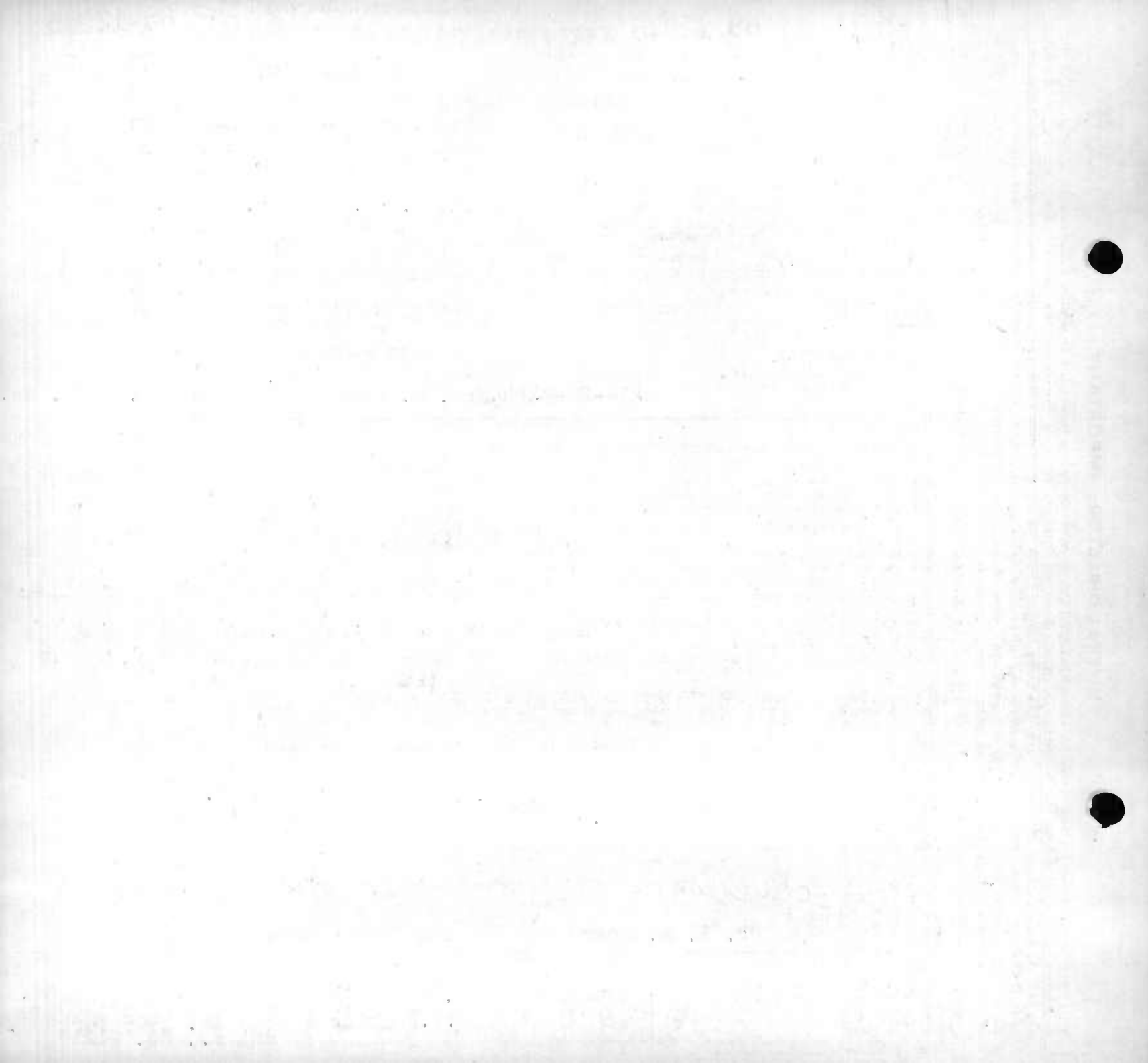
23A. SIGNATURE **I. A. Arer M.D.** DEGREE **Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒** 23B. DATE SIGNED **12/26/69**

23C. PHYSICIAN'S NAME (Type) **Dr. I. A. Arer** DEGREE **The Good Samaritan Hospital**

24A. BURIAL CREMATION, REMOVAL (Specify) **Burial** 24B. DATE **12/30/69** 24C. NAME OF CEMETERY or CREMATORY **Baltimore National** 24D. LOCATION (City, town, or county) (State) **Baltimore Md.**

25A. DATE REC'D BY HEALTH DEPT. **DEC 30 1969** 25B. NAME OF REGISTRAR **Robert E. Taylor, M.D.** 25C. FUNERAL DIRECTOR **M.W. Jenkins & Sons Co.** ADDRESS **4905 York Rd. Balto., Md. 21212**

VS 150-REV. 1/1/68

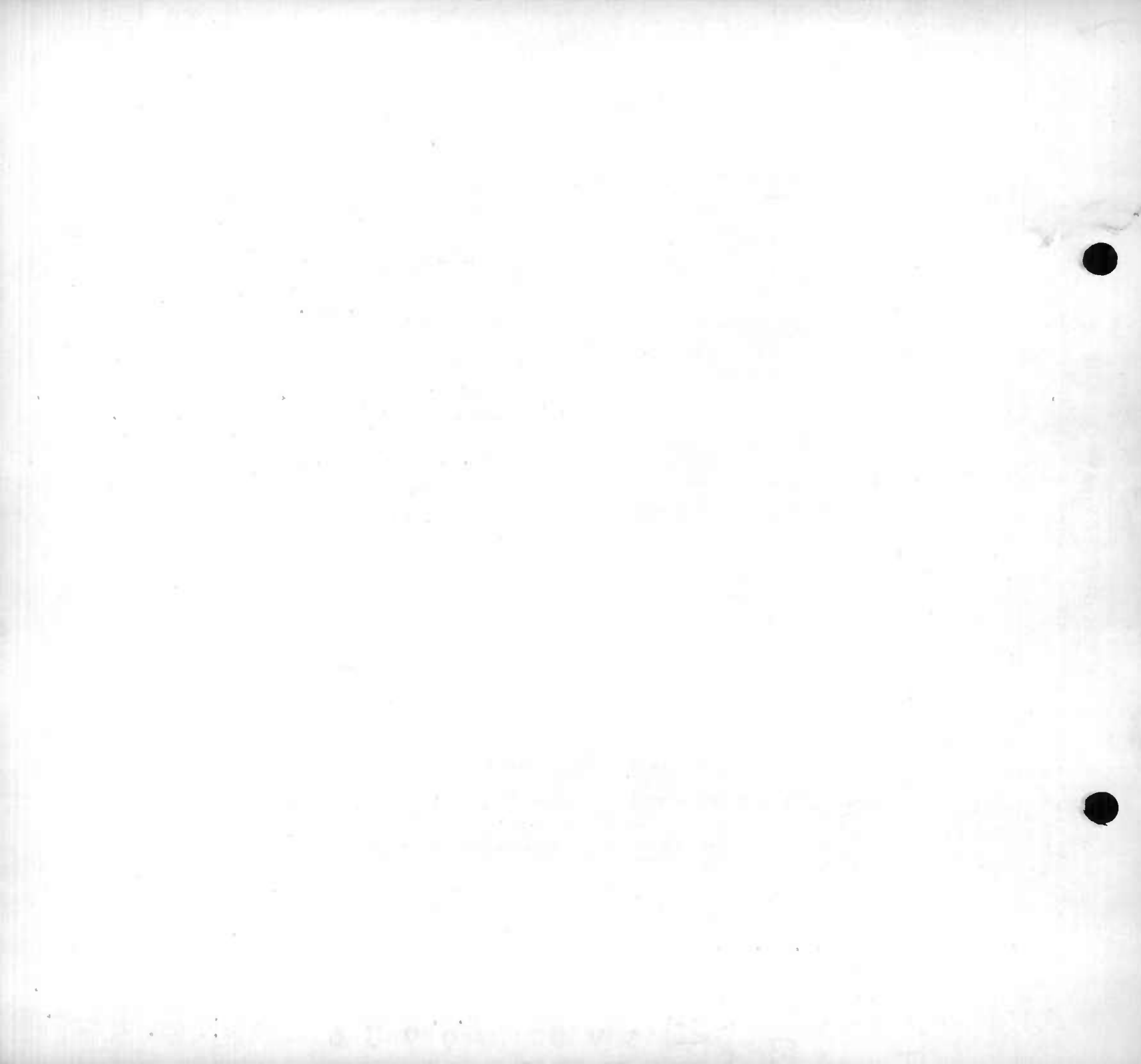




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <b>69 12950</b>	
BIRTH NO. <b>L-600</b>		69 12950 <b>CERTIFICATE OF DEATH</b>	
1. NAME OF DECEASED (Type or Print) <b>Eleanor Dieter Leary</b>		2. DATE AND HOUR OF DEATH <b>12-25-69 145 A.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>00 Wynnewood Towers Apt #705</b>		4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>2711</b>	
5. SEX <b>F</b>		6. RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <b>2-2-1891</b>		9. AGE (In years last birthday) <b>78</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Homemaker</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Dieter</b>		14. MOTHER'S MAIDEN NAME <b>Crouch</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Fairfax Leary, Jr.</b>		ADDRESS <b>2301 Packard Bldg. Phila. Pa.</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>412.21</b> <b>Congestive Heart failure</b> <b>Chronic Hypertension</b> <b>Hypertensive Cardiovascular disease</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2-3 days</b> <b>3-5 wks</b> <b>Gradual over 5 yrs</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) <b>No</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>Dec 25 1969</b> to <b>12-25 1969</b> , that (I) (we) last saw the deceased alive on <b>Dec 25 1969</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <b>W. H. Woody</b>		23B. DATE SIGNED <b>12-25-69</b>	
23C. PHYSICIAN'S NAME (Type) <b>Dr. W. H. Woody</b>		23D. ADDRESS <b>1403 Park Ave Baltimore Md.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12-30-69</b>	
24C. NAME OF CEMETERY or CREMATORY <b>US Naval Academy</b>		24D. LOCATION (City, town, or county) (State) <b>Annapolis, Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 30 1969</b>		25B. NAME OF REGISTRAR <b>Robert E. Fisher, M.D.</b>	
25C. FUNERAL DIRECTOR <b>H.W. Jenkins &amp; Sons Co.</b>		ADDRESS <b>4905 York Rd. Balto., Md. 21212</b>	



## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

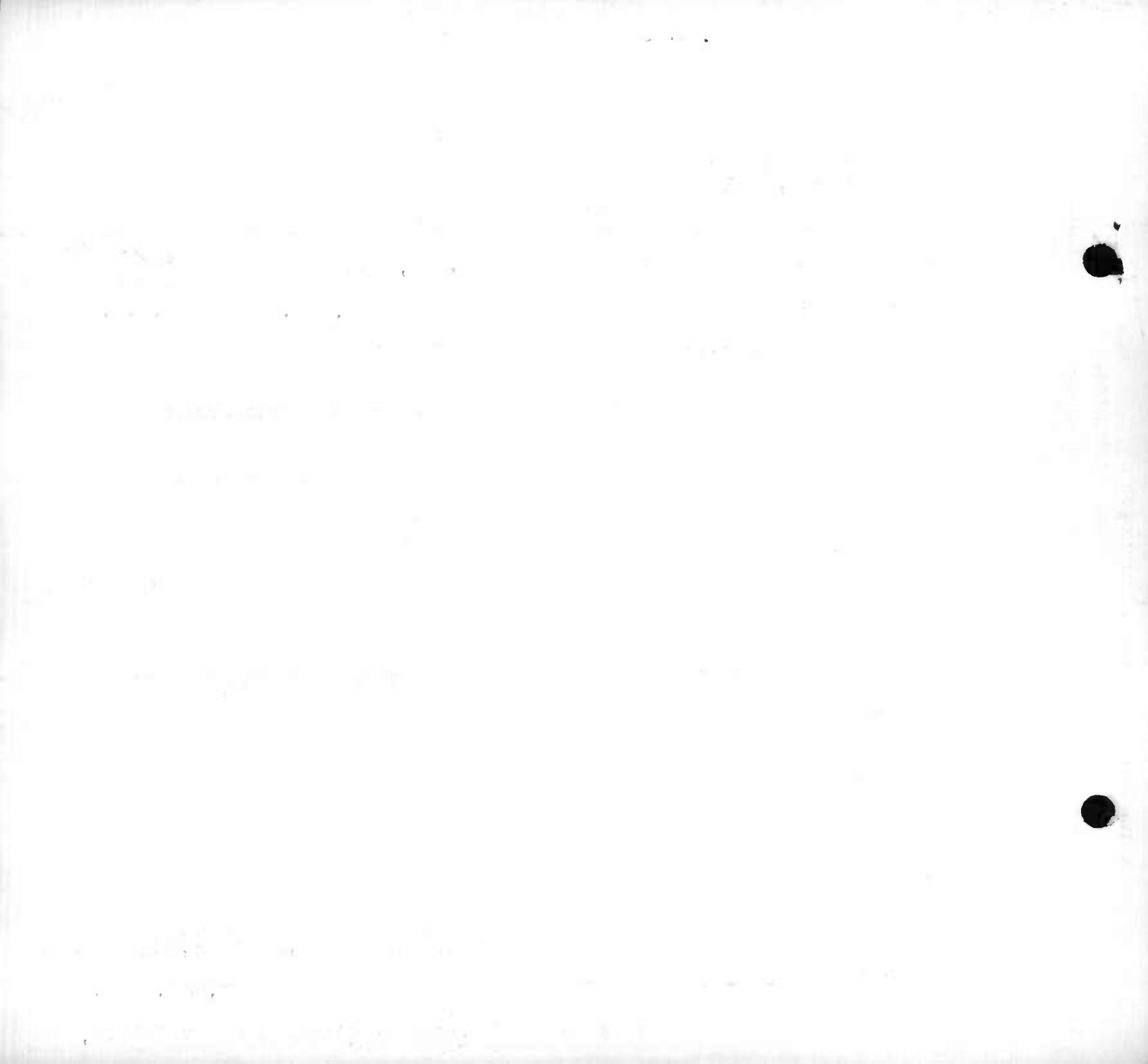
69 12951

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO.

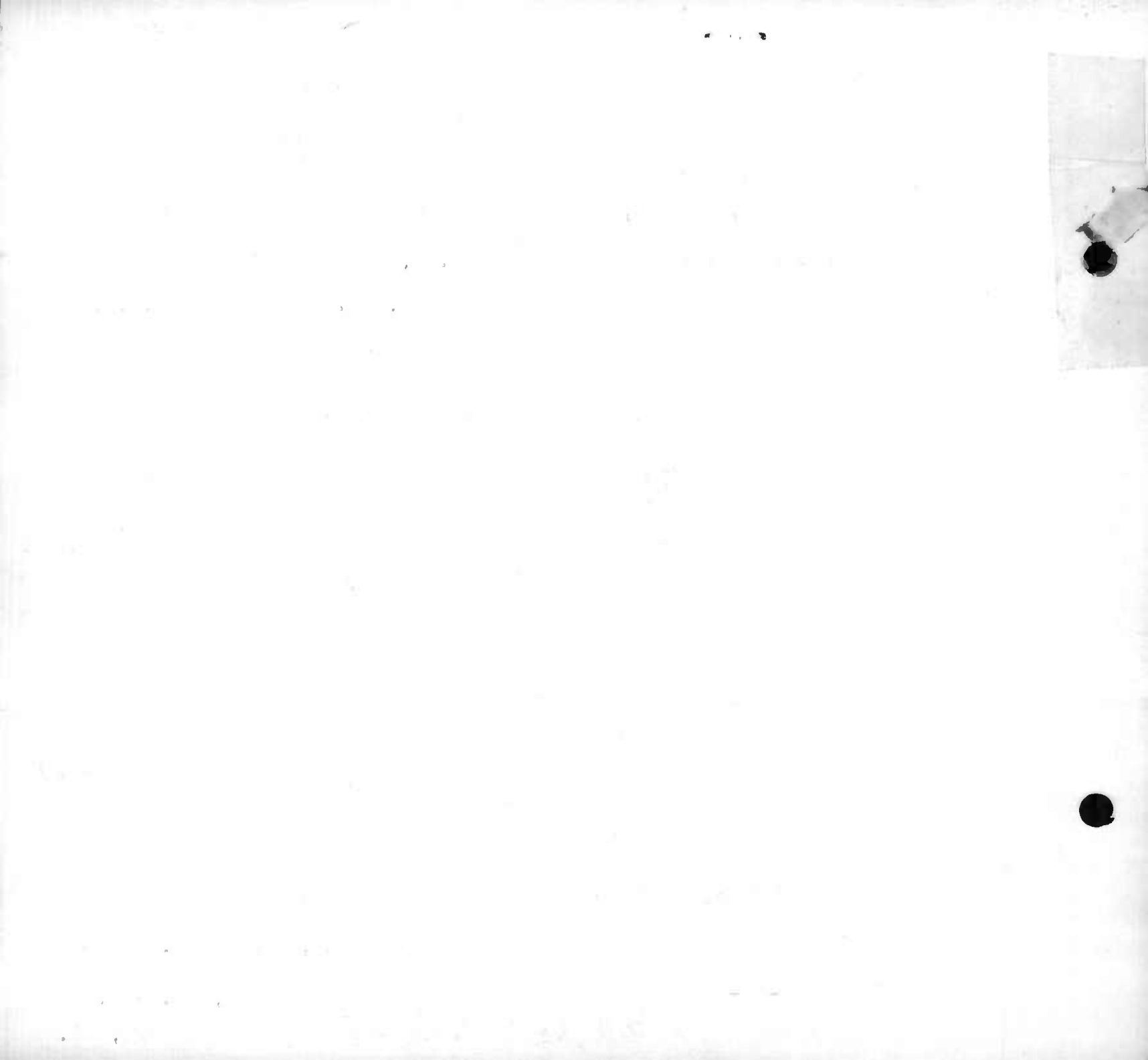
69 12951

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>MRS MARY JANE WOOD</u>		2. DATE AND HOUR OF DEATH <u>12/18/69</u> <u>6 15</u> A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Caroline</u>		5. CITY OR TOWN <u>Preston</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION <u>4940 Eastern Avenue</u> <u>Baltimore City Hospitals</u> <u>21224</u>		E. STREET AND NUMBER <u>Box 236</u>		F. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <u>Female</u>	6. RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 27, 1926</u>	9. AGE (in years last birthday) <u>43</u>	10. If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>house wife</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>none</u>		11. BIRTHPLACE (State or foreign country) <u>Andersontown, Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Everett Passwaters</u>		14. MOTHER'S MAIDEN NAME <u>Ida Liden</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Records: BCH-4940 Eastern Avenue 21224</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <u>PULMONARY + CARDIAC INSUFFICIENCY</u> 1. This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death. 2. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>PULMONARY + CARDIAC INSUFFICIENCY</u> (B) <u>SECONDARY TO SEPSIS</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>BURNS (~ 43%)</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 hr.</u> <u>6 days</u>	
19A. DATE OF OPERATION <u>TRACHEOSTOMY</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>PULMONARY UPPER RESPIRATORY OBSTRUCTION</u>		20A. AUTOPSY? (Yes or No) <u>YES</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>YES</u>		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH? Notify medical examiner <input checked="" type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>HOME</u>	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>HOUSE - Box 236, PRESTON, MD.</u>		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) <u>12/12/69</u> <u>5:10 AM</u>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>	
21F. HOW DID INJURY OCCUR? <u>FIRE (OIL STOVE EXPLODED)</u>		22. I certify that (I) (this hospital) attended the deceased from <u>12/12</u> 19 <u>69</u> to <u>12/18</u> 19 <u>69</u> that (I) (we) last saw the deceased alive on <u>12/18/69</u> 19 <u>69</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		23A. SIGNATURE <u>Ivan LeFlore, M.D.</u> DEGREE	
23B. DATE SIGNED <u>12/18/69</u>		23C. PHYSICIAN'S NAME (Typed) <u>Ivan LeFlore</u> DEGREE		23D. ADDRESS <u>Baltimore City Hospitals</u> <u>4940 Eastern Avenue, Baltimore, Maryland 21224</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>burial</u>		24B. DATE <u>12-20-69</u>		24C. NAME OF CEMETERY or CREMATORY <u>Bloomery Cemetery</u>	
24D. LOCATION (City, town, or county) (State) <u>Federalburg, Md. RFD.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>DEC 30 1969</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, Md.</u>	
25C. FUNERAL DIRECTOR <u>William J. Williams</u>		ADDRESS <u>Federalburg, Md</u>			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 69 12952		BALTIMORE CITY HEALTH DEPARTMENT		X		REG. NO. 69 12952	
1. NAME OF DECEASED (Type or Print) <u>ROBIN WOOD</u>				2. DATE AND HOUR OF DEATH <u>12/18/69</u> <u>1:30 A.M.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>BALTIMORE CITY HOSPITALS</u> <u>4940 Eastern Avenue, Baltimore, Maryland</u>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Caroline</u> C. CITY OR TOWN <u>Preston</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER <u>Box 236</u> <u>21655</u>			
5. SEX <u>F</u> Female	6. RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 28, 1958</u>	9. AGE (In years lost birthday) <u>11</u>	10. Under 1 Yr. Months: Days: 11. Under 24 Hrs. Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>student</u>		11. BIRTHPLACE (State or foreign country) <u>Easton, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Thomas Wood</u>				14. MOTHER'S MAIDEN NAME <u>Mary Jane Passwaters</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT ADDRESS <u>Records: BCH-4940 Eastern Avenue 21224</u>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. <u>RESPIRATORY INSUFFICIENCY</u> <u>SECONDARY TO ~ 35% BURNS</u> <u>+ PULMONARY BURNS</u>				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) <u>NONE</u>			
19. DATE OF OPERATION <u>TRACEOSTOMY</u>				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>UPPER RESPIRATORY OBSTRUCTION</u>		20A. AUTOPSY? (Yes or No) <u>YES</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>HOME</u>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>Box 236 - PRESTON, MD.</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>YES</u>	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <u>12/12/69 5:10 AM</u>		21E. INJURY OCCURRED ( ) White At Work ( ) Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? <u>FIRE (OIL STOVE EXPLODED)</u>			
22. I certify that (I) (this hospital) attended the deceased from <u>DECEMBER 12 1969</u> to <u>DECEMBER 18 1969</u> that (I) (we) last saw the deceased alive on <u>12/18 1969</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Ivan LeFlore, M.D.</u>				23B. DATE SIGNED <u>12/18/69</u>		23C. PHYSICIAN'S NAME (Type) <u>Ivan LeFlore</u>	
23D. ADDRESS <u>Baltimore City Hospitals</u> <u>4940 Eastern Avenue, Baltimore, Md. 21224</u>				23E. FUNERAL DIRECTOR ADDRESS <u>Federalburg, Md. RFD.</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>burial</u>		24B. DATE <u>12-20-69</u>		24C. NAME OF CEMETERY or CREMATORY <u>Bloomery Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Federalburg, Md. RFD.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JEC 30 1969</u>		25B. NAME OF REGISTRAR <u>John E. Gaber, M.D.</u>		25C. FUNERAL DIRECTOR ADDRESS <u>Federalburg, Md.</u>			



69 12953

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO.

69 12953

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

SHERMAN, THOMAS G

2. DATE AND HOUR OF DEATH

12/19/69 5:00 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)31  
Baltimore City Hospitals  
4940 Eastern Avenue  
Baltimore, Maryland 212244. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)  
A. STATE

Maryland

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒NO ☐

E. STREET AND NUMBER

5035 E. Preston Street 21224

5. SEX

Male

6. RACE

White

7. MARRIED ☒NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

8. DATE OF BIRTH

3-27-1905

9. AGE (in years  
last birthday)

64

10. Under 1 Tr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Carpenter

10B. KIND OF BUSINESS OR INDUSTRY

Construction

11. BIRTHPLACE (State or foreign country)

West Virginia

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

William Sherman

14. MOTHER'S MAIDEN NAME

Rebecca Wetzel

15. Was Deceased Ever in U. S. Armed Forces?

(Yes, no or unknown) (If yes, give war or dates of service)

Unknown

16. SOCIAL  
SECURITY NO.

705-12-3088

17. INFORMANT

ADDRESS

Records: BCH-4940 Eastern Avenue 21224

18. 225-91-320-4  
DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving  
rise to the above cause (A) stating the  
UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

Meningitis

(B)

DUE TO, OR AS A CONSEQUENCE OF:

Meningitis

(C)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATHII  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

NO

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING ☐  
OR CONTRIBUTING ☐ CAUSE OF  
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME  
OF INJURY  
(APPROX)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At  
Work ☐Not While  
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 12/18/69 19 to 12/19/69 19  
that (I) (we) lost saw the deceased alive on 12/18 19 69 and that in (my) (our) opinion death occurred on the date  
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

J.R. Wands MD

DEGREE

Attending ☐  
Phys.Med. ☐  
DirectorStaff ☒  
Phys.

23B. DATE SIGNED

12/19/69

23C. PHYSICIAN'S  
NAME (Type)

J.R. Wands

23D. ADDRESS

DEGREE

Baltimore City Hospitals

4940 Eastern Avenue, Baltimore, Md. 21224

24A. BURIAL, CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

23 Dec 1969

24C. NAME of CEMETERY or CREMATORY

Gardens of Faith Cem. (Baltimore County), Md.

24D. LOCATION

(City, town, or county)

(State)

25A. DATE REC'D BY HEALTH DEPT.

DEC 30 1969

25B. NAME OF REGISTRAR

Robert E. Taylor, M.D.

25C. FUNERAL DIRECTOR

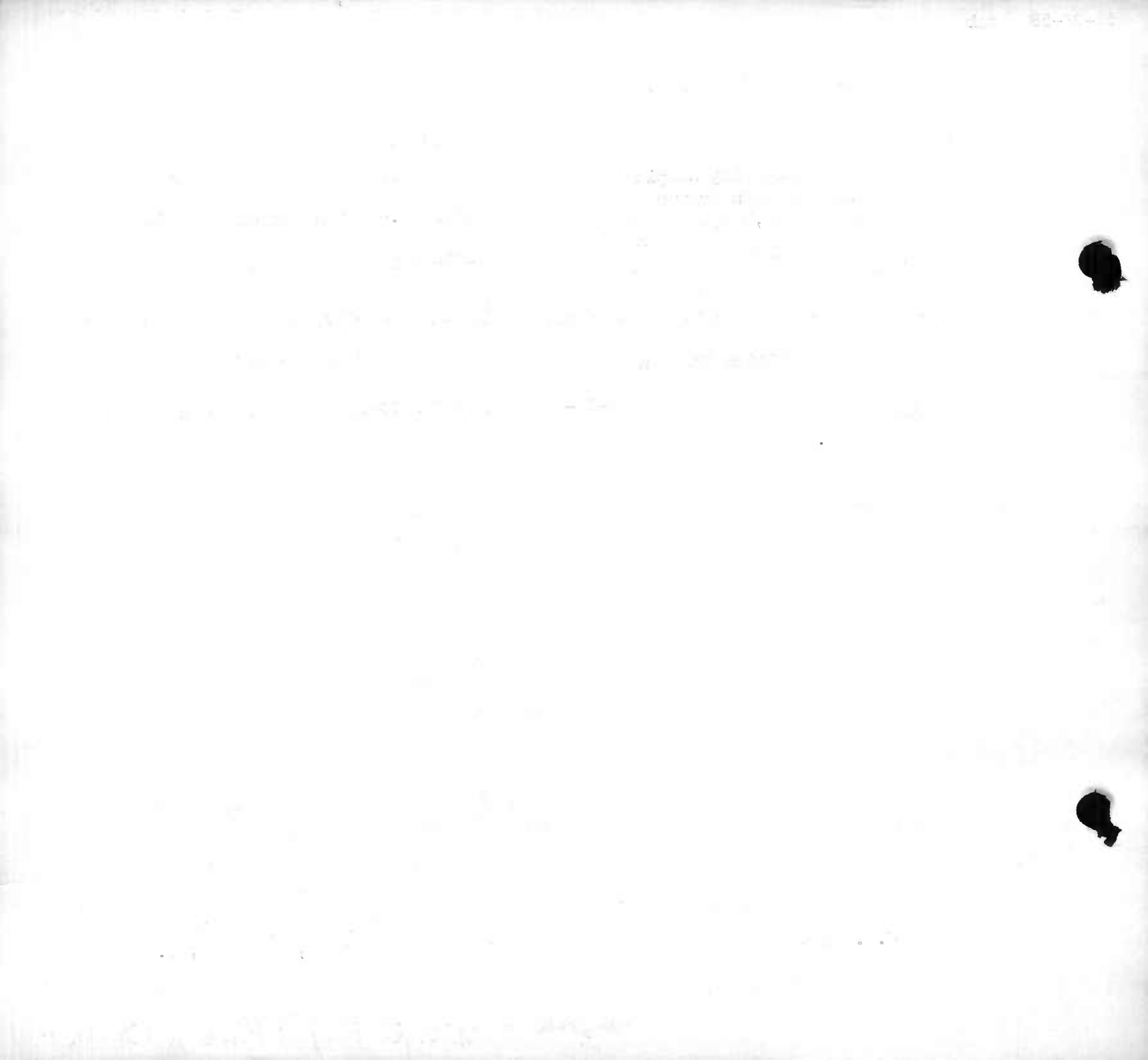
George Dunbar Home

ADDRESS

Baltimore, Md.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.





This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

69 12954 CERTIFICATE OF DEATH				REG. NO. <u>62</u>	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>Henrietta</u> <del>Henrietta Ohren</del>		2. DATE AND HOUR OF DEATH <u>12-27-69 5:30 AM</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>2201</u>	
FULL NAME OF HOSPITAL OR INSTITUTION		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Harbor View NCC</u>		C. CITY OR TOWN <u>Baltimore</u>	
CERTIFICATE AMENDED - 12/30/69				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <u>106 E Hughes St.</u>	
5. SEX <u>Female</u>	6. RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1891</u>	9. AGE (In years last birthday) <u>78</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>	
13. FATHER'S NAME <u>Joseph Ohren</u>		14. MOTHER'S MAIDEN NAME <u>Caroline Junge</u>		12. CITIZEN OF WHAT COUNTRY? <u>Germany</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>139-20-3436</u>		17. INFORMANT <u>Mrs. James Martin</u>	
18. <u>436.9</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <u>Pneumonia</u>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Old Cerebrovascular Accident</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Arteriosclerosis, Hypertension</u>		(B) DUE TO, OR AS A CONSEQUENCE OF: <u>?</u>		(C) DUE TO, OR AS A CONSEQUENCE OF: <u>?</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>February</u> 19 <u>69</u> to <u>12-27</u> 19 <u>69</u> , that (we) lost her the deceased alive on <u>12-27</u> 19 <u>69</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Volando V. Gonsky M.D.</u>				23B. DATE SIGNED <u>12-28-69</u>	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS		23E. FUNERAL DIRECTOR <u>JOHN F. DEBNEY, INC.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>12/30/69</u>		24C. NAME OF CEMETERY or CREMATORY <u>St. Matthews Cem.</u>	
24D. LOCATION (City, town, or county) <u>Baltimore, Md.</u>		24E. ADDRESS <u>715 Light St.</u>		24F. ADDRESS <u>715 Light St.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>DEC 30 1969</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>		25C. FUNERAL DIRECTOR <u>JOHN F. DEBNEY, INC.</u>	

12/30/69 - Correction form from funeral director.

*[Handwritten signature]*

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <b>M-560</b>		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <b>69 12955</b>	
1. NAME OF DECEASED (Type or Print) <b>John Monroe</b>			2. DATE AND HOUR OF DEATH <b>12-24-69 5am</b> M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <b>Key Circle Hospice</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MD.</b> B. COUNTY <b>1702</b>		
FULL NAME OF HOSPITAL OR INSTITUTION <b>Key Circle Hospice</b>			C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER <b>1214 Eutaw Place</b>		
5. SEX <b>male</b>	6. RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3-31-1901</b>	9. AGE (In years last birthday) <b>68</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farm work</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>	
13. FATHER'S NAME <b>William Monroe</b>		14. MOTHER'S MAIDEN NAME <b>Mary Hill</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>71 223-729112</b>		17. INFORMANT <b>Mrs C. Bowman</b> ADDRESS <b>2007 Guilford Ave</b>	
18. <b>412.4 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>Respiratory failure 2 weeks</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Chronic bronchitis 4-5 yrs</b> <b>ASVD + Chronic bronchitis - 11 -</b> <b>Glaucoma - 11 -</b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 weeks</b>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from <b>11-25-69</b> to <b>12-24-69</b> , that (I) (we) lost saw the deceased alive on <b>12-23-69</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Richard R. Rigler</b>				23B. DATE SIGNED <b>12-24-69</b>	
23C. PHYSICIAN'S NAME (Type) <b>RICHARD R. RIGLER MD</b>				23D. ADDRESS <b>141 W. Overlea Ave # 21206</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12-26-69</b>		24C. NAME OF CEMETERY or CREMATORY <b>Mount Calvary Cmtx</b>	
24D. LOCATION (City, town, or county) (State) <b>Anne Arundel Co. Md.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>DEC 30 1969</b>			
25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR <b>Collick F. H.</b>			
25D. ADDRESS <b>2431 E. Oliver St</b>					

54

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <b>7-300</b>		69 12956		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. <b>69 12956</b>	
<b>CERTIFICATE OF DEATH</b>							
1. NAME OF DECEASED (Type or Print) <b>Tate, William Randolph</b>				2. DATE AND HOUR OF DEATH <b>12/18/69 7:45 P.M.</b>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION <b>48 Maryland General</b> (If not in hospital or institution, give street address or location)				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>2710</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b> D. STREET ADDRESS (If rural, give location) <b>5117 Kenilworth Ave 21212</b>			
5. SEX <b>Male</b>	6. RACE <b>Negro</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (Specify) <b>Widowed</b>		8. DATE OF BIRTH <b>7-26-07</b>	9. AGE (In years last birthday) <b>62</b>	10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Butcher</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Food Store</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Bunley Hargrave</b>				14. MOTHER'S MAIDEN NAME <b>Annie Kelly</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>214-05-1442</b>		17. INFORMANT <b>Mrs. Lois Wright</b> ADDRESS <b>5104 Kenilworth Ave.</b>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>3-19-21</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <b>Pneumonia</b>				INTERVAL BETWEEN ONSET AND DEATH <b>days</b>			
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Chronic obstructive airway disease yrs.</b>							
<b>II</b>							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>12/17</b> 19 <b>69</b> to <b>12/18</b> 19 <b>69</b> , that (I) (we) last saw the deceased alive on <b>12/18</b> 19 <b>69</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Louis E. Dunger</b> M.D.				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>12/18/69</b>	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12-23-69</b>		24C. NAME OF CEMETERY or CREMATORY <b>Probus Memorial PK. Probus, Md.</b>		24D. LOCATION (City, town, or county) (State)	
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 30 1969</b>		25B. NAME OF REGISTRAR <b>Robert E. Gentry</b>		25C. FUNERAL DIRECTOR <b>Randolph J. Collick</b>		ADDRESS <b>2431 E. Oliver St</b>	

1900

1900

Maryland Canal

1900

1900

Male

Female

Female

Female

1900

Female

1900

Female

1900

1900

1900

1900

1900

Female

1900

Female

Female

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="float: right;">69 12957</span>	
H-626		69 12957		CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Ralph Hargrove</i>		2. DATE AND HOUR OF DEATH <i>12-20-69</i> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>804</i>			
FULL NAME OF HOSPITAL OR INSTITUTION <i>00</i> <i>2116 E. Biddle St.</i>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <i>Baltimore</i> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <i>Male</i> 6. RACE <i>negro</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>2-25-31</i> 9. AGE (In years last birthday) <i>38</i>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Laborer</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>?</i>		11. BIRTHPLACE (State or foreign country) <i>Baltimore, Md.</i>	
13. FATHER'S NAME <i>Burley Hargrove</i>		14. MOTHER'S MAIDEN NAME <i>Thelma Watts</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>no</i>		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Thelma Hargrove</i> ADDRESS <i>2116 E. Biddle St.</i>	
18. <i>412.4 I</i>		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Cardiac Collapse</i>		<i>10 min.</i>	
ANTECEDENT CAUSES		(B) <i>Cardiovascular Heart Disease</i>		<i>2 yrs</i>	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) <i>Sarcoidosis</i>		<i>12 yrs</i>	
II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <i>NONE</i>			
19A. DATE OF OPERATION <i>0 NONE</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>NONE</i>		20A. AUTOPSY? (Yes or No) <i>NO</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <i>NONE</i>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <i>NONE</i>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <i>NONE</i>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>12/19 1969</i> to <i>12/20 1969</i> , that (I) (we) lost saw the deceased alive on <i>7:20 AM on 12/20 1969</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>John H. Daugherty MD</i>		Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <i>12/20/69</i>	
23C. PHYSICIAN'S NAME (Type) <i>John H. Daugherty, M.D.</i>		23D. ADDRESS <i>2437 E. Preston Street Baltimore, Maryland 21213</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>12-23-69</i>		24C. NAME OF CEMETERY OR CREMATORY <i>St. Calvary Cemetery</i>	
24D. LOCATION (City, town, or county) <i>Anne Arundel Co., Md.</i>		24E. STATE <i>Md.</i>			
25A. DATE REC'D BY HEALTH DEPT. <i>DEC 30 1969</i>		25B. NAME OF REGISTRAR <i>John E. ...</i>		25C. FUNERAL DIRECTOR <i>Edmund J. ...</i> ADDRESS <i>2431 E. Oliver St.</i>	



214 E. 13th St.  
10th Ave  
1st Floor  
Chicago, Ill.  
Thomas Watson

214 E. 13th St.  
10th Ave  
1st Floor  
Chicago, Ill.  
Thomas Watson

Carroll College  
10th Ave  
Chicago, Ill.  
Thomas Watson

10th Ave  
Chicago, Ill.  
Thomas Watson

John H. Davenport  
10th Ave  
Chicago, Ill.  
Thomas Watson



# FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT <b>CERTIFICATE OF DEATH</b>		REG. NO. <span style="font-size: 2em;">69 12958</span>
X-532 69 12958		
BIRTH NO. <span style="font-size: 1.5em;">X-532</span>		
1. NAME OF DECEASED (Type or Print) <b>KOONTZ, ZOLA N</b>		2. DATE AND HOUR OF DEATH <b>12-25-1969 8:25 A.M.</b>
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>44 UNION MEMORIAL HOSPITAL</b>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTO. CO.</b> C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>620 WALKER AVENUE</b>
5. SEX <b>F</b>	6. RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Homemaker</b>		8. DATE OF BIRTH <b>11-29-'89</b> 9. AGE (In years last birthday) <b>80</b>
10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>AMBROSE STREAKER</b>		14. MOTHER'S MAIDEN NAME <b>EMILY BUCKINGHAM</b>
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>220-24-6886B</b>
17. INFORMANT <b>Mr. Wilber L. Koontz</b>		ADDRESS <b>620 Walker Avenue</b>
18. <b>56091</b> CAUSE OF DEATH		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES  DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:  (B) <i>intestinal gangrene &amp; perforation</i> <b>MM</b> DUE TO, OR AS A CONSEQUENCE OF:  (C) _____
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		
19A. DATE OF OPERATION <b>11-29-1969</b>	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>INTESTINAL OBSTRUCTION</b>	20A. AUTOPSY? (Yes or No) <b>yes</b>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?
22. I certify that (I) <u>(this hospital)</u> attended the deceased from <u>12-13</u> 19 <u>69</u> to <u>12-25</u> 19 <u>69</u> that (I) <u>(we)</u> last saw the deceased alive on <u>8:25 AM 12-25</u> 19 <u>69</u> and that in (my) <u>(our)</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>(We)</u> <u>(did)</u> <u>(did not)</u> view the body after death.		
23A. SIGNATURE <b>Kasuke Tsujimoto M.D.</b>		23B. DATE SIGNED <b>12-25</b>
23C. PHYSICIAN'S NAME (Type) <b>KASUKE TSUJIMOTO M.D.</b>		23D. ADDRESS <b>UNION MEMORIAL HOSPITAL 33RD AND CALVERT STS. BALTIMORE</b>
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>12/29/69</b>	24C. NAME OF CEMETERY OR CREMATORY <b>Woodlawn Cemetery</b>
24D. LOCATION (City, town, or county) <b>Baltimore, Maryland</b>		
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 31 1969</b>	25B. NAME OF REGISTRAR <b>Robert E. Tabor</b>	25C. FUNERAL DIRECTOR <b>Mitchell Wiedefeld</b>
ADDRESS <b>6500 York Road 21212</b>		

REVIEW MEMORIAL 12-14-32  
F WHITE 11-24-32

MARYLAND  
AMROSE STEAKER  
EMILY BUCKINGHAM

12-14-32

12-14-32  
12-14-32  
12-14-32

KARKE TOLIMTO M.D.  
KARKE TOLIMTO M.D.  
UNION MEMORIAL HOSPITAL  
12-14-32

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

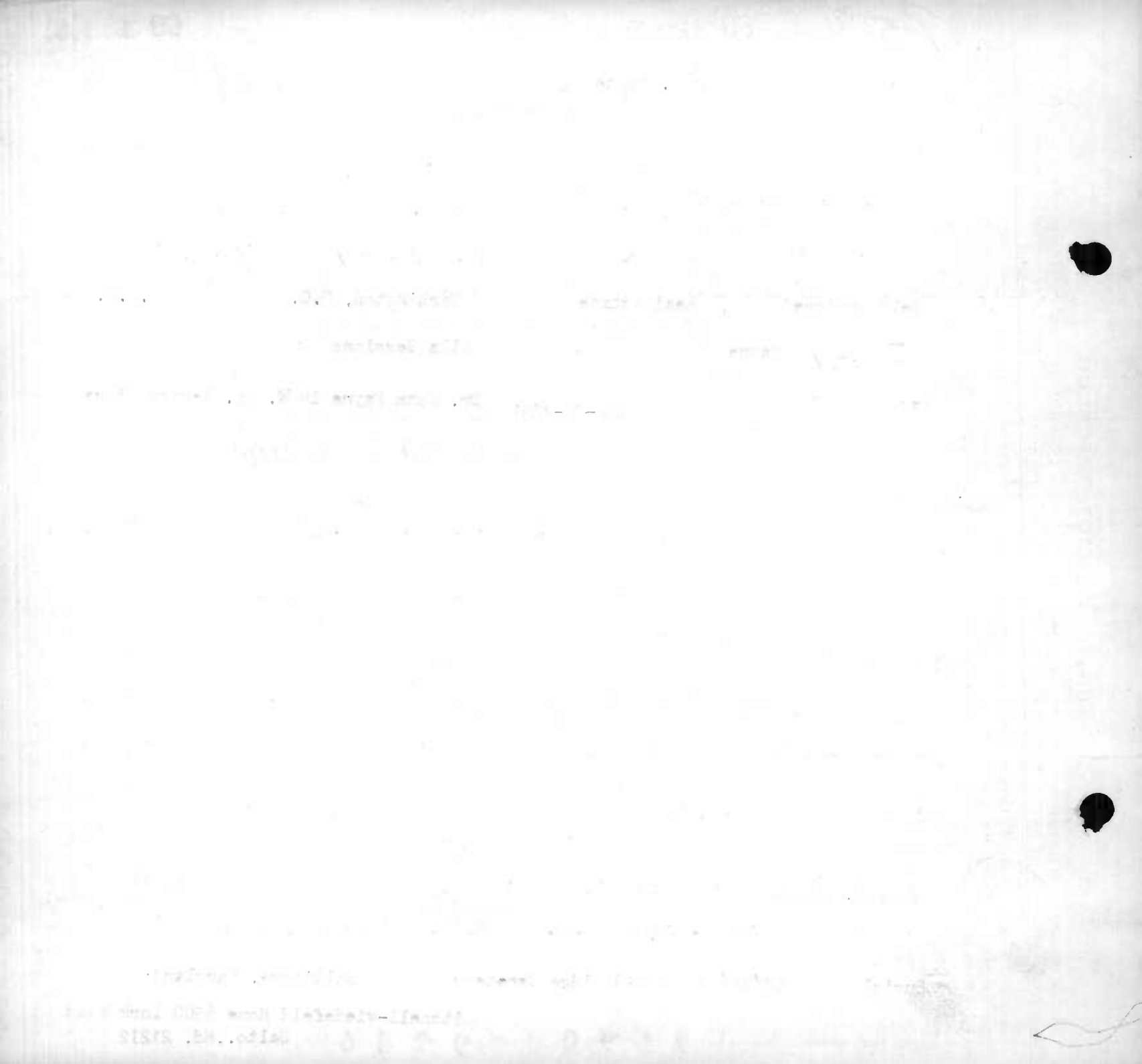
B-563		69 12959		BALTIMORE CITY HEALTH DEPARTMENT		X REG. NO. 69 12959	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) MRS HILDA W. BOMHARDT			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				2. DATE AND HOUR OF DEATH 12/25/69 9:07 A.M.			
FULL NAME OF HOSPITAL OR INSTITUTION 48 MARYLAND GEN. HOSPITAL				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE 5300			
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				C. CITY OR TOWN Rodgers Forge INSIDE CITY LIMITS? BALTIMORE			
				E. STREET AND NUMBER 55 MURDOCK RD.			
5. SEX F	6. RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/30/05	9. AGE (In years last birthday) 64	10. Under 1 Yr. Months: Days: Hours: Min.	11. Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME Clinton Armstrong			14. MOTHER'S MAIDEN NAME Bessie Hardison				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. 214-24-7746		17. INFORMANT George C. Bomhardt 55 Murdock Rd. Balto, Md.		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) 286.31			CAUSE OF DEATH (A) IMMEDIATE CAUSE G.I. bleeding DUE TO, OR AS A CONSEQUENCE OF: (B) Excessive Anticoagulation? DUE TO, OR AS A CONSEQUENCE OF: (C) _____				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). II							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from _____ 19 _____ to _____ 19 _____ that (I) (we) last saw the deceased alive on _____ 12/25/1969 _____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE M. S. Al-Ibrahim M.S. AL-IBRAHIM				23B. DATE SIGNED 12/25/69			
23C. PHYSICIAN'S NAME (Type) M.S. AL-IBRAHIM				23D. ADDRESS Md Gen Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/27/69		24C. NAME of CEMETERY or CREMATORY Dulaney Valley Mem. Gd.		24D. LOCATION (City, town, or county) (State) Cockeysville Balto Md	
25A. DATE REC'D BY HEALTH DEPT. DEC 31 1969		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Michael W. Wedefeld		ADDRESS Home 6500 York Rd Balto, Md. 21212	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <span style="float: right;">69 12960</span>	
69 12960 CERTIFICATE OF DEATH			
BIRTH NO. <span style="font-size: 1.5em;">7-500</span>		1. NAME OF DECEASED (Type or Print) <b>John A. Payne</b>	
2. DATE AND HOUR OF DEATH <b>12/26/69 11:40 A.M.</b>		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD	
4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>1202</b>		FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>1 E. University Parkway</b>	
C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <b>1 E. University Parkway</b>			
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12-1-99</b>
9. AGE (In years last birthday) <b>70</b>		10. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Self Employed</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Real Estate</b>	
11. BIRTHPLACE (State or foreign country) <b>Washington, D.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>JOHN Payne</b>		14. MOTHER'S MAIDEN NAME <b>Ella Sessions</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes WWI</b>		16. SOCIAL SECURITY NO. <b>220-22-7251</b>	
17. INFORMANT <b>Dr. John Payne 14 W. Mt. Vernon Place</b>		ADDRESS	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>Pulmonary Edema</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Carcinomatous</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 hour</b> <b>4 mos</b>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) <b>YES</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>NO</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>19</b> to <b>19</b> , that (I) (we) lost saw the deceased alive on <b>19</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <b>William F. Fritz</b>		23B. DATE SIGNED <b>12/26/69</b>	
23C. PHYSICIAN'S NAME (Type) <b>William F. Fritz, M.D.</b>		23D. ADDRESS <b>2 W. University Parkway Baltimore, Maryland 21218</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12/29/69</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Druid Ridge Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 31 1969</b>		25B. NAME OF REGISTRAR <b>Robert E. Fisher, M.D.</b>	
25C. FUNERAL DIRECTOR <b>Mitchell Wiedefeld</b>		ADDRESS <b>Home 6500 York Road Balto., Md. 21212</b>	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

69 12961

BALTIMORE CITY HEALTH DEPARTMENT

## CERTIFICATE OF DEATH

REG. NO.

69 12961

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>NELLIE VAN FOSSEN ASHCOM</b>		2. DATE AND HOUR OF DEATH <b>12-29-69 1:30 P. M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <b>35 CHURCH HOME &amp; HOSPITAL</b>		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>1401</b>		C. CITY OR TOWN <b>BALTIMORE</b>	
FULL NAME OF HOSPITAL OR INSTITUTION <b>35 CHURCH HOME &amp; HOSPITAL</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		E. STREET AND NUMBER <b>1735 Bolton Street, City 21217</b>	
5. SEX <b>Female</b>	6. RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2-13-1875</b>	9. AGE (In years lost birthday) <b>85 94</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SCHOOL TEACHER</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>BALTIMORE, MARYLAND</b>	
13. FATHER'S NAME <b>NATHANIEL ASHCOM</b>		14. MOTHER'S MAIDEN NAME <b>EMILY VAN FOSSEN</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>220 44 0761</b>		17. INFORMANT: Self - 1961 <b>Nellie V. Ashcom, 1735 Bolton St. 21217</b>	
18. <b>486 X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenic, etc. It means the disease, injury or complication which caused death.) <b>Respiratory insufficiency</b>		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Pneumonia, LLL</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>few days</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b>		(B) DUE TO, OR AS A CONSEQUENCE OF: <b>AscVD; Dehydration</b>		(C) <b>?</b>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>12-28</b> 19 <b>69</b> to <b>12-29</b> 19 <b>69</b> that (I) (we) last saw the deceased alive on <b>12-29</b> 19 <b>69</b> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Rodellio M. Lim</b>		23B. DATE SIGNED <b>12-29-69</b>		23C. PHYSICIAN'S NAME (Type) <b>RODELIO M. LIM</b>	
23D. ADDRESS <b>CH H</b>		23E. ATTENDING PHYS. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23F. DEGREE	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1/2/70</b>		24C. NAME OF CEMETERY or CREMATORY <b>Loudon Park Cemetery</b>	
24D. LOCATION <b>Baltimore, Maryland</b>		24E. NAME OF REGISTRAR <b>Robert E. Taylor, M.D.</b>		24F. FUNERAL DIRECTOR <b>STEWART &amp; MOWEN CO. 108 W. North Av. City 1</b>	

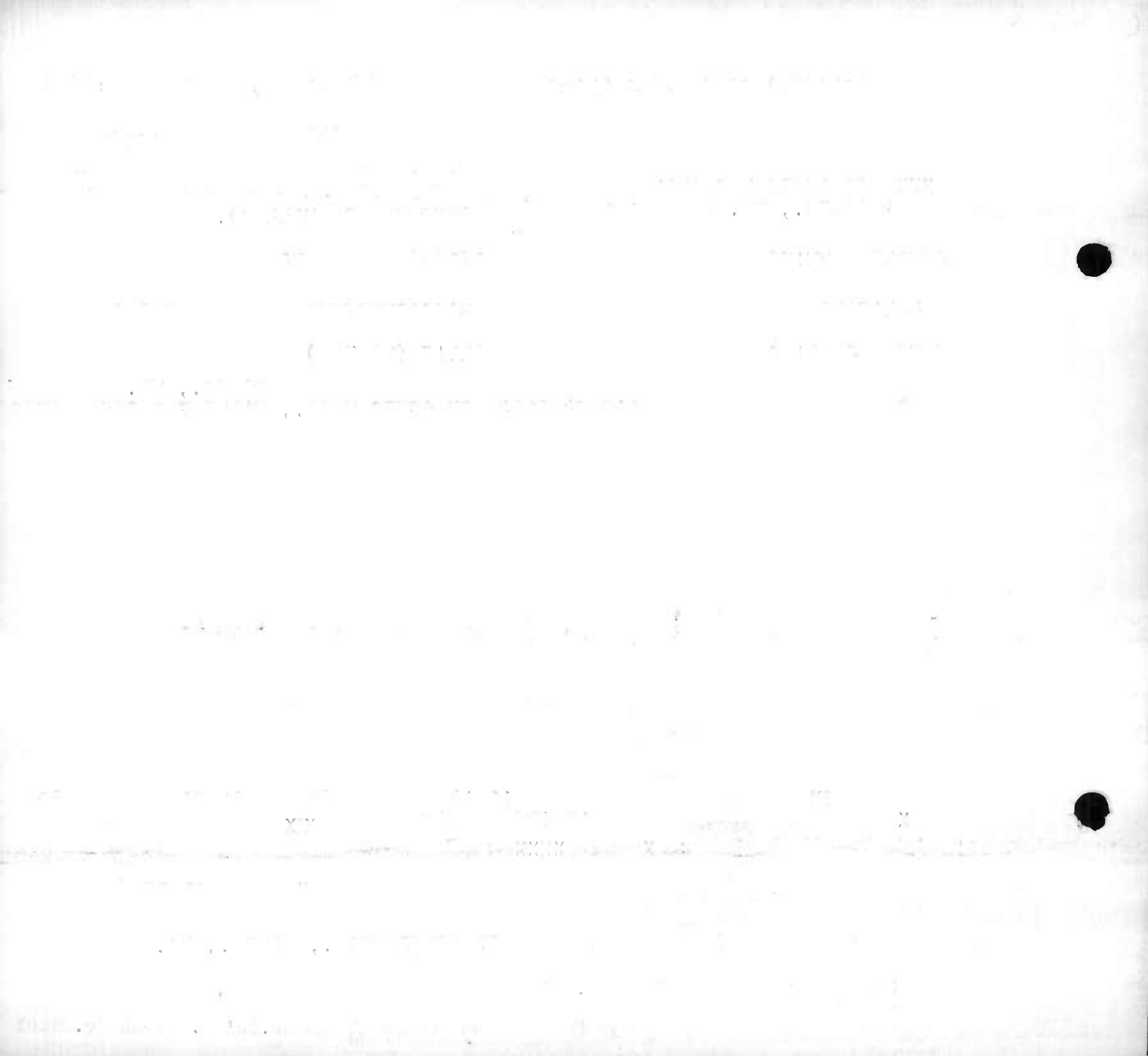




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>69 12962</u>
BIRTH NO. <u>69 12962</u>		CERTIFICATE OF DEATH		
1. NAME OF DECEASED (Type or Print) <u>(SISTER) GERTRUDE COLLINS</u>		2. DATE AND HOUR OF DEATH <u>DECEMBER 27, 1969</u> <u>3:30PM</u> M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>ST AGNES HOSPITAL</u> <u>BALTO., MD.</u>		A. STATE <u>MD</u> B. COUNTY <u>BALTO</u> C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER <u>4000 FOREST HILL RD.</u> <u>2841</u>		
5. SEX <u>FEMALE</u>	6. RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7/2/96</u>	9. AGE (in years last birthday) <u>73</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RELIGIOUS</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MASSACHUSETTS</u>
12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>		13. FATHER'S NAME <u>JOHN W COLLINS</u>		
14. MOTHER'S MAIDEN NAME <u>ALLIE (NORTON)</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		
16. SOCIAL SECURITY NO. <u>219 54 0264</u>		17. INFORMANT <u>BALTO., MD.</u> ADDRESS <u>ST AGNES HOSP., WILKENS &amp; CATON AVES</u>		
18. <u>25091</u> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <u>Bilateral pneumonia</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Diabetes</u>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>NO</u>
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that <u>(X)</u> (this hospital) attended the deceased from <u>12 14</u> 19 <u>69</u> to <u>12 27</u> 19 <u>69</u> that <u>(X)</u> (we) last saw the deceased alive on <u>12/17/</u> 19 <u>69</u> and that <u>(X)</u> (our) opinion death occurred on the date and hour and from the causes stated above. <u>(X)</u> (We) (did) <u>(X)</u> view the body after death.				
23A. SIGNATURE <u>Ching-Hui Tsai, M.D.</u> DEGREE				23B. DATE SIGNED <u>12 27 69</u>
23C. PHYSICIAN'S NAME (Type) <u>CHING-HUI TSAI</u> DEGREE				23D. ADDRESS <u>ST AGNES HOSP., BALTO., MD.</u>
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	24B. DATE <u>12/30/69</u>	24C. NAME OF CEMETERY OR CREMATORY <u>Villa St. Michael on grounds Seton Inst. City</u>		24D. LOCATION (City, town, or county) (State) <u>21215</u>
25A. DATE REC'D BY HEALTH DEPT. <u>DEC 31 1969</u>		25B. NAME OF REGISTRAR <u>Robert S. J. J. J.</u>		25C. FUNERAL DIRECTOR <u>STEWART &amp; BOWEN CO.</u> ADDRESS <u>108 W. North Av. 21201</u>



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		69 12963		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO.		69 12963	
1. NAME OF DECEASED (Type or Print) <b>LOUISE PENTZ SHERMAN</b> <b>Sherman, Louise P.</b>				2. DATE AND HOUR OF DEATH <b>December 28, '69</b> <b>2<sup>45</sup> a.m.</b>					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>1203</b>		C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION <b>Keswick</b> <b>7700 West 40th St.</b>				E. STREET AND NUMBER <b>2620 Guilford Avenue</b>					
5. SEX <b>Female</b>	6. RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>5-27-1903</b>		9. AGE (In years lost birthday) <b>66</b>		If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland (Aberdeen)</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William Henry Pentz</b>				14. MOTHER'S MAIDEN NAME <b>Aileen Raymond</b>		15. Informant Brother <b>Allen Z. Pentz</b> ADDRESS <b>613 E. Gittings Ave. 21212</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>213-12-9988B</b>		17. Informant Brother <b>Allen Z. Pentz</b> ADDRESS <b>613 E. Gittings Ave. 21212</b>			
18. <b>410.9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Myocardial infarction</b>				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Anterior wall heart disease</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Hours</b>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b>				(B) DUE TO, OR AS A CONSEQUENCE OF: <b>Paraplegia, 1<sup>st</sup> to Transverse myelitis</b>		(C) DUE TO, OR AS A CONSEQUENCE OF: <b>Years</b>			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>Paraplegia, 1<sup>st</sup> to Transverse myelitis</b>									
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <b>July 25</b> 19 <b>68</b> to <b>Dec 28</b> 19 <b>69</b> , that (I) (we) last saw the deceased alive on <b>Dec 27</b> 19 <b>69</b> and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <b>RK GUNORY MD</b>				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <b>12-28-69</b>			
23C. PHYSICIAN'S NAME (Type) <b>RK GUNORY MD</b>				23D. ADDRESS <b>2 W University Pkwy (2818)</b>					
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12/31/69</b>		24C. NAME of CEMETERY or CREMATORY <b>Spesutia Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Perryman, Harford Co., Md.</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 31 1969</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor, MD.</b>		25C. FUNERAL DIRECTOR ADDRESS <b>STEWART &amp; MOWEN CO. 108 W. North Av. 21201</b>					

Sherman, George F.

December 24, 1903

Kewwick  
700 West  
4th St.

2-24-1903

F W x

Hausman

William Henry Peaty

No

215-12-1903  
Virginia W. Peaty - President  
Citizen Payment  
Hansford

B-635

69 12964

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 69 12964

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>HUBERT HERBERT BREADON</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> <b>December 25, 1969</b>		Hour <b>M.</b>	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>4355 Nicholas Avenue</b>		3. DATE PRONOUNCED DEAD Month Day Year <b>December 25, 1969</b>		Hour <b>4:15 A.</b>	
5. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>2642</b>					
6. SEX <b>Male</b>	7. RACE <b>White</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Baltimore</b>	
9. DATE OF BIRTH <b>18 May 1895</b>		10. AGE (In years last birthday) <b>74</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
11. BIRTHPLACE (State or foreign country) <b>New York</b>		12. CITIZEN OF <b>U.S.A.</b>		E. STREET AND NUMBER <b>4355 Nicholas Avenue</b>	
13. FATHER'S NAME <b>HUGH BREADON</b>		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>COMM. OFFICER</b>			
15. MOTHER'S MAIDEN NAME <b>EVA RUSSELL</b>		16. KIND OF BUSINESS OR INDUSTRY <b>ARMY ORDINANCE</b>			
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes WWII</b>		17. SOCIAL SECURITY NO. <b>217-34-L 150</b>		18. INFORMANT <b>BERTHA BREADON</b>	
19. <b>412.41</b>		CAUSE OF DEATH <b>Arteriosclerotic cardiovascular disease</b>		ADDRESS <b>9333 NICHOLAS AVE 21206</b>	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) DUE TO, OR AS A CONSEQUENCE OF:			
(C) _____					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
20A. DATE OF OPERATION <b>412.41</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) <b>No</b>	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (if in Baltimore City, give exact location) INJURY OCCUR?	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <b>Charles S. Springate</b>		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Charles S. Springate, M.D.</b>				ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
				ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>burial</b>		24B. DATE <b>29 Dec 69</b>		24C. NAME OF CEMETERY or CREMATORY <b>DARWOOD CEM.</b>	
24D. LOCATION (City, town, or county) (State) <b>BALTO. CO., MD.</b>					
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 31 1969</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor, M.D.</b>		25C. FUNERAL DIRECTOR <b>ULRICH FUNERAL HOME</b>	
				ADDRESS <b>BALTO., MD. 21206</b>	

ACADEMIC RECORD

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

5-525		BALTIMORE CITY HEALTH DEPARTMENT	
69 12965		REG. NO. 69 12965	
BIRTH NO.		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <u>MA MARY SANSONE</u>		2. DATE AND HOUR OF DEATH <u>12-24-69</u> <u>12:44</u> <u>A.M.</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>BON SELOURS HOSPITAL</u> <u>2025 W. FAYETTE ST</u> <u>BALTIMORE MD. 21223</u>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>2737</u> C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>4402 BELAIR RD</u>	
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-28-01</u>
9. AGE (In years lost birthday) <u>68</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE - RESTAURANTEUR - RESTAURANT</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>UNKNOWN PAUL MICELI</u>		14. MOTHER'S MAIDEN NAME <u>MS SHELLIE JOSEPHINE JEPPI</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>PAUL SANSONE</u>		ADDRESS <u>4418 CEDAR GARDEN RD</u>	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <u>ABDOMINAL MALIGNANCY.</u> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:  (B) DUE TO, OR AS A CONSEQUENCE OF:  (C) DUE TO, OR AS A CONSEQUENCE OF:  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION <u>12-19-69</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>INTESTINAL OBSTRUCTION</u>	
20A. AUTOPSY? (Yes or No) <u>NO</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (H) (this hospital) attended the deceased from <u>12 DEC</u> 19 <u>69</u> to <u>24 DEC</u> 19 <u>69</u> that (I) (we) last saw the deceased alive on <u>23rd Dec</u> 19 <u>69</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death.			
23A. SIGNATURE <u>John C. Kerr M.D.</u>		23B. DATE SIGNED <u>12-24-69</u>	
23C. PHYSICIAN'S NAME (Type) <u>JOHN C. KERR M.D.</u>		23D. ADDRESS <u>BON SELOURS HOSPITAL 2025 W. FAYETTE ST #23</u>	
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE <u>12/27/69</u>	24C. NAME OF CEMETERY OR CREMATORY <u>HOLY REDEEMER</u>	24D. LOCATION (City, town, or county) (State) <u>BALTIMORE MD</u>
25A. DATE REC'D BY HEALTH DEPT. <u>DEC 31 1969</u>	25B. NAME OF REGISTRAR <u>Robert E. Taylor</u>	25C. FUNERAL DIRECTOR <u>THEODORE W. HIRCH</u>	ADDRESS <u>4210 BELMONT RD</u>





# FUNERAL DIRECTOR: IMPORTANT

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BIRTH NO.		69 12966		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO.		69 12966	
1. NAME OF DECEASED (Type or Print) <i>HOLLINGSWORTH</i>				2. DATE AND HOUR OF DEATH <i>12/29/69 2:45 PM</i>					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <i>35 CHURCH HOME &amp; HOSPITAL</i>				4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) A. STATE <i>MD</i> B. COUNTY <i>2636</i>					
FULL NAME OF HOSPITAL OR INSTITUTION <i>CHURCH HOME &amp; HOSPITAL</i>				C. CITY OR TOWN <i>DUNDALK</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
5. SEX <i>M</i>				6. RACE <i>W</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>9/25/87</i>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired Ship Joiner</i>				10B. KIND OF BUSINESS OR INDUSTRY		9. AGE (in years last birthday) <i>82 yrs</i>		11. BIRTHPLACE (State or foreign country) <i>Delaware</i>	
13. FATHER'S NAME <i>Joseph Hollingsworth</i>				14. MOTHER'S MAIDEN NAME <i>Ellen Clark</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>NO</i>				16. SOCIAL SECURITY NO. <i>213055134</i>		17. INFORMANT <i>LOUISE C. HOLLINGSWORTH 6728 PINE AV</i>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <i>412.4 I</i> (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>Cardiac arrest</i>				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Arteriosclerotic Cardiac vascular Disease</i>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				(B) DUE TO, OR AS A CONSEQUENCE OF: <i>Emphysema, Ethanol Poisoning</i>					
19A. DATE OF OPERATION <i>0</i>				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>12/13</i> 19 <i>69</i> to <i>12/29</i> 19 <i>69</i> that (I) (we) last saw the deceased alive on <i>12/24/1969</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <i>John</i>				23B. DATE SIGNED					
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS					
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)			
<i>BURIAL</i>		<i>12/27/69</i>		<i>OAK LAWN</i>		<i>COLLIER MD</i>			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS			
<i>DEC 31 1969</i>		<i>Robert E. Taylor</i>		<i>GLADYS H. FUNERAL HOME DUNDALK MD</i>					



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S-143 69 12967		BALTIMORE CITY HEALTH DEPARTMENT		X		REG. NO. 69 12967	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>ERNEST SHIFFLETT</u>		2. DATE AND HOUR OF DEATH <u>12/28/69</u> <u>3:45</u> P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u>		C. CITY OR TOWN <u>DUNDALK</u>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION <u>31</u> <u>Baltimore City Hospitals</u> <u>4940 Eastern Ave.</u> <u>Baltimore, Md. 21224</u>		E. STREET AND NUMBER <u>6525 Colgate Ave.</u> <u>21222</u> <u>005</u>					
5. SEX <u>Male</u>	6. RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-11-07</u>	9. AGE (In years last birthday) <u>62</u>	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>CONSTRUCTION</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.A.</u>	
13. FATHER'S NAME <u>Will Shifflett</u>		14. MOTHER'S MAIDEN NAME <u>Vena</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>226-18-274D</u>	
17. INFORMANT <u>BCH Records: Baltimore, Md. 21224</u>		ADDRESS <u>4940 Eastern Ave.</u>					
18. <u>481X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>Respiratory Arrest</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>RVL Pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>at least 6 days</u>			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION <u>0</u>	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) <u>No</u>	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?					
22. I certify that (this hospital) attended the deceased from <u>12/22</u> 19 <u>69</u> to <u>12/28</u> 19 <u>69</u> that (we) last saw the deceased alive on <u>12/28</u> 19 <u>69</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Leonard N. Feingold M.D.</u>		23B. DATE SIGNED <u>12/28/69</u>		23C. PHYSICIAN'S NAME (Type) <u>LEONARD N. FEINGOLD M.D.</u>			
23D. ADDRESS <u>Baltimore City Hospitals</u> <u>4940 Eastern Ave. Baltimore, Md. 21224</u>		23E. ATTENDING PHYSICIAN <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>					
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE <u>BUR. REMOVAL 12/31/69</u>	24C. NAME OF CEMETERY OR CREMATORY <u>BUCK MT. EUTHELICAL CEM.</u>		24D. LOCATION (City, town, or county) (State) <u>EARLYVILLE, VA.</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>DEC 31 1969</u>	25B. NAME OF REGISTRAR <u>Robert E. Farber M.D.</u>	25C. FUNERAL DIRECTOR <u>CLERICH FUNERAL HOME BAGO, MD.</u>		ADDRESS <u>FOR HAWKINS CHARLOTTEVILLE, VA.</u>			

4940 Eastern Ave. Baltimore, Md. 21224  
Baltimore City Hospitals

# FUNERAL DIRECTOR: IMPORTANT

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D-320		69 12968		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 69 12968	
BIRTH NO. 69 12968				CERTIFICATE OF DEATH			
M.E. CASE NO.				2. DATE AND HOUR OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>Dodds Fannie W.</u>				12-29-69 6:25 a.m. 6.25 A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION  90 <u>Harford Gardens Nursing Home</u> (If not in hospital or institution, give street address or location)				A. STATE <u>Maryland</u>			
				B. COUNTY <u>2757</u>			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u>			
				D. STREET ADDRESS (If rural, give location) <u>2822 Rosalie Avenue</u>			
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Widowed</u>	8. DATE OF BIRTH <u>9-20-85</u>	9. AGE (In years last birthday) <u>84</u>	10. Under 1 Yr. Months Days	11. Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>Thomas Newton Wheelley</u>			14. MOTHER'S MAIDEN NAME <u>Frances Owens</u>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. <u>216-09-2427</u>		17. INFORMANT <u>Mrs. Oliver Roth 2822 Rosalie Avenue</u>		
18. <u>412.1 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) <u>Arteriosclerotic heart disease</u> DUE TO (B) <u>with hypertension</u> DUE TO (C) _____			INTERVAL BETWEEN ONSET AND DEATH <u>2 years</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>April 21</u> 19 <u>69</u> to <u>December 29</u> 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>December 29</u> 19 <u>69</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>E. J. Alessi</u>				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <u>12/29/69</u>	
23C. PHYSICIAN'S NAME (Type) <u>E. J. Alessi</u>				23D. ADDRESS <u>6217 Harford Rd</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>12/31/69</u>		24C. NAME of CEMETERY or CREMATORY <u>Loudon Park Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore Maryland</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>DEC 31 1969</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor</u>		25C. FUNERAL DIRECTOR ADDRESS <u>Leonard J. Ruck Inc. 5305 Harford Rd. 21214</u>			



**69 12969** BALTIMORE CITY HEALTH DEPARTMENT  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH** REG. NO. **69 12969**

BIRTH NO. \_\_\_\_\_

1. NAME OF DECEASED (Type or Print) <b>WILLIAM INNERS</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> _____ M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>Union Memorial Hospital</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>12 28 69 3:05 P.M.</b>	
6. SEX <b>Male</b>		7. RACE <b>White</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Balto.</b>	
9. DATE OF BIRTH <b>April 5, 1889.</b>		10. AGE (In years lost birthday) <b>80</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF <b>USA</b>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Plumber</b>		14B. KIND OF BUSINESS OR INDUSTRY	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		17. SOCIAL SECURITY NO. <b>215-01-0978</b>	
18. INFORMANT <b>Mrs. Edna Diefel</b>		ADDRESS <b>(Same)</b>	
19. <b>412.41</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>Arteriosclerotic cardiovascular disease</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		(B) _____ DUE TO, OR AS A CONSEQUENCE OF:	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Russell S. Fisher</b> EXAMINER'S NAME (Type)		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1/3/70.</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Mt. Olivet Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 31 1969</b>		25B. NAME OF REGISTRAR <b>Robert L. Valley</b>	
25C. FUNERAL DIRECTOR <b>Leonard J. Ruck, Inc.</b>		ADDRESS <b>Balto. Md. 21214</b>	

VS 151-REV. 7/1/68





FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

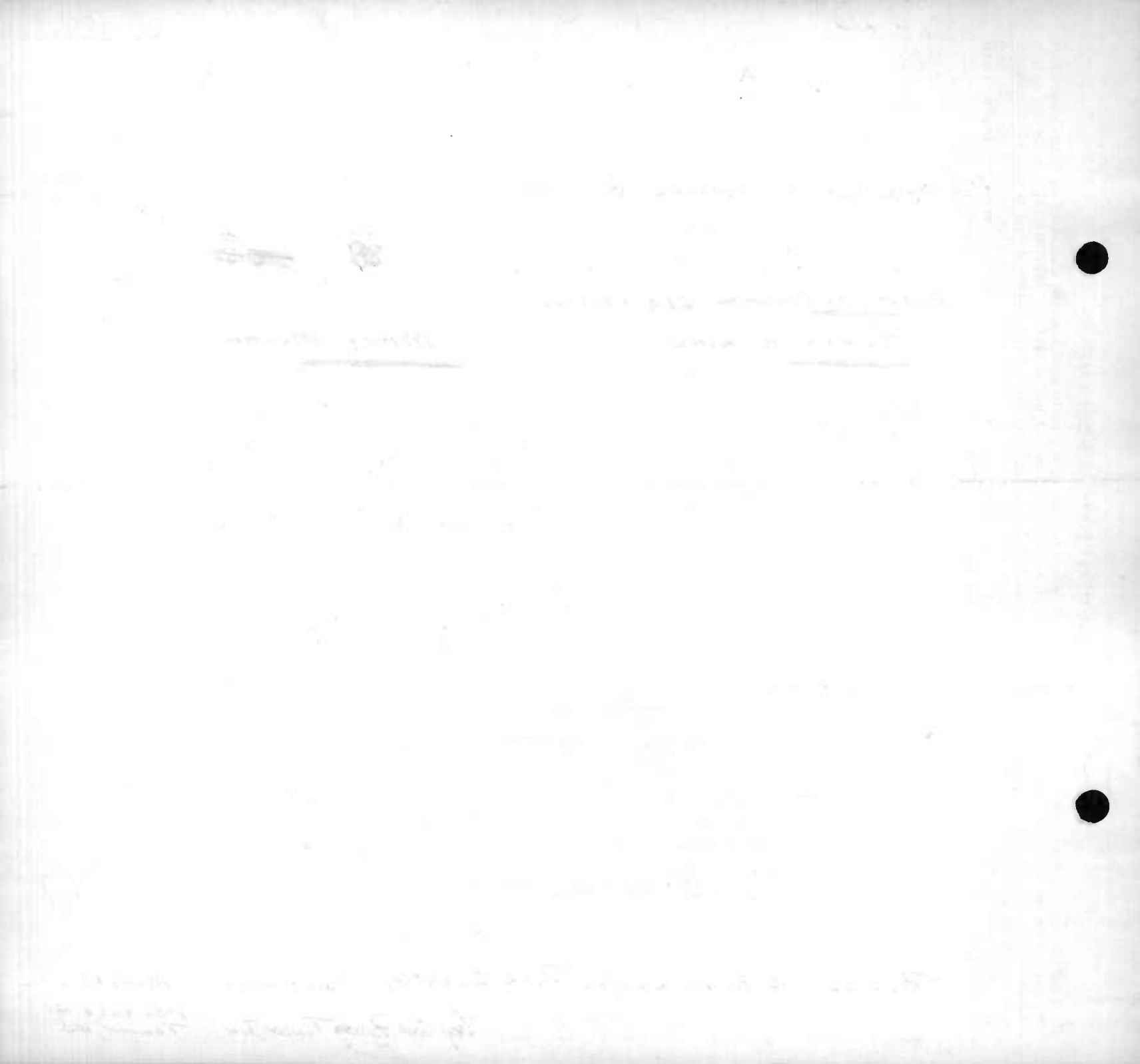
<p><b>5-416</b>      <b>69 12970</b>      <b>BALTIMORE CITY HEALTH DEPARTMENT</b></p> <p style="font-size: 1.2em; font-weight: bold;">CERTIFICATE OF DEATH</p>		<p>REG. NO. <b>69 12970</b></p>	
<p><b>BIRTH NO.</b></p>		<p><b>2. DATE AND HOUR OF DEATH</b></p> <p style="font-size: 1.2em;">12/28/69 12:40 P.M.</p>	
<p><b>1. NAME OF DECEASED</b> (Type or Print) <u>Lena Silverstein</u></p>		<p><b>4. USUAL RESIDENCE</b> (Where deceased lived, if institution; residence before admission) A. STATE <u>MD</u> B. COUNTY <u>2717</u></p>	
<p><b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b></p> <p>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Levinthal Hebrew Home &amp; Infirmary</u> <u>91</u></p>		<p><b>C. CITY OR TOWN</b> <u>Balto</u> <b>D. INSIDE CITY LIMITS?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></p> <p><b>E. STREET AND NUMBER</b> <u>Greenway Belvedere Ave</u></p>	
<p><b>5. SEX</b> <u>F</u></p>	<p><b>6. RACE</b> <u>W</u></p>	<p><b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/></p>	<p><b>8. DATE OF BIRTH</b> <u>1980</u> <b>9. AGE</b> (In years last birthday) <u>89</u></p>
<p><b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)</p>		<p><b>10B. KIND OF BUSINESS OR INDUSTRY</b></p>	
<p><b>11. BIRTHPLACE</b> (State or foreign country)</p>		<p><b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u></p>	
<p><b>13. FATHER'S NAME</b> <u>Morris</u></p>		<p><b>14. MOTHER'S MAIDEN NAME</b></p>	
<p><b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u></p>		<p><b>16. SOCIAL SECURITY NO.</b></p>	<p><b>17. INFORMANT</b> <u>Noop's Clerk</u> <b>ADDRESS</b></p>
<p><b>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>450 X 1</u></p>		<p><b>CAUSE OF DEATH</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Acute Pulmonary embolism</u></p>	
<p><b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p>		<p>(B) DUE TO, OR AS A CONSEQUENCE OF:</p> <p>(C) _____</p>	
<p><b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</b></p>		<p><u>ASCVD</u></p>	
<p><b>19A. DATE OF OPERATION</b></p>		<p><b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b></p>	
<p><b>20A. AUTOPSY?</b> (Yes or No) <u>No</u></p>		<p><b>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</b></p>	
<p><b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (Notify medical examiner)</p>		<p><b>21B. PLACE OF INJURY</b> (a.g., in or about home, farm, factory, street, office bldg., etc.)</p>	
<p><b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)</p>		<p><b>21D. TIME OF INJURY</b> (Month) (Day) (Year) (Hour)</p>	
<p><b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>		<p><b>21F. HOW DID INJURY OCCUR?</b></p>	
<p><b>22. I certify that (I) (this hospital) attended the deceased from <u>April 1</u> 19<u>57</u> to <u>Dec 28</u> 19<u>69</u> that (I) (we) lost saw the deceased alive on <u>Dec 28</u> 19<u>69</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</b></p>			
<p><b>23A. SIGNATURE</b> <u>Ellen S Caplan MD</u></p>		<p><b>23B. DATE SIGNED</b> <u>12/28/69</u></p>	
<p><b>23C. PHYSICIAN'S NAME</b> (Type)</p>		<p><b>23D. ADDRESS</b></p>	
<p><b>24A. BURIAL CREMATION, REMOVAL</b> (Specify) <u>Burial</u></p>		<p><b>24B. DATE</b> <u>12/30/69</u></p>	
<p><b>24C. NAME of CEMETERY or CREMATORY</b> <u>Balto Hebrew</u></p>		<p><b>24D. LOCATION</b> (City, town, or county) (State) <u>Balto</u> <u>MD</u></p>	
<p><b>25A. DATE REC'D BY HEALTH DEPT.</b> <u>DEC 31 1969</u></p>		<p><b>25B. NAME OF REGISTRAR</b> <u>9000</u></p>	
<p><b>25C. FUNERAL DIRECTOR</b> <u>Suburban SS/Quinn</u></p>		<p><b>ADDRESS</b> <u>9610 Reisterstown Rd</u></p>	



# FUNERAL DIRECTOR: IMPORTANT

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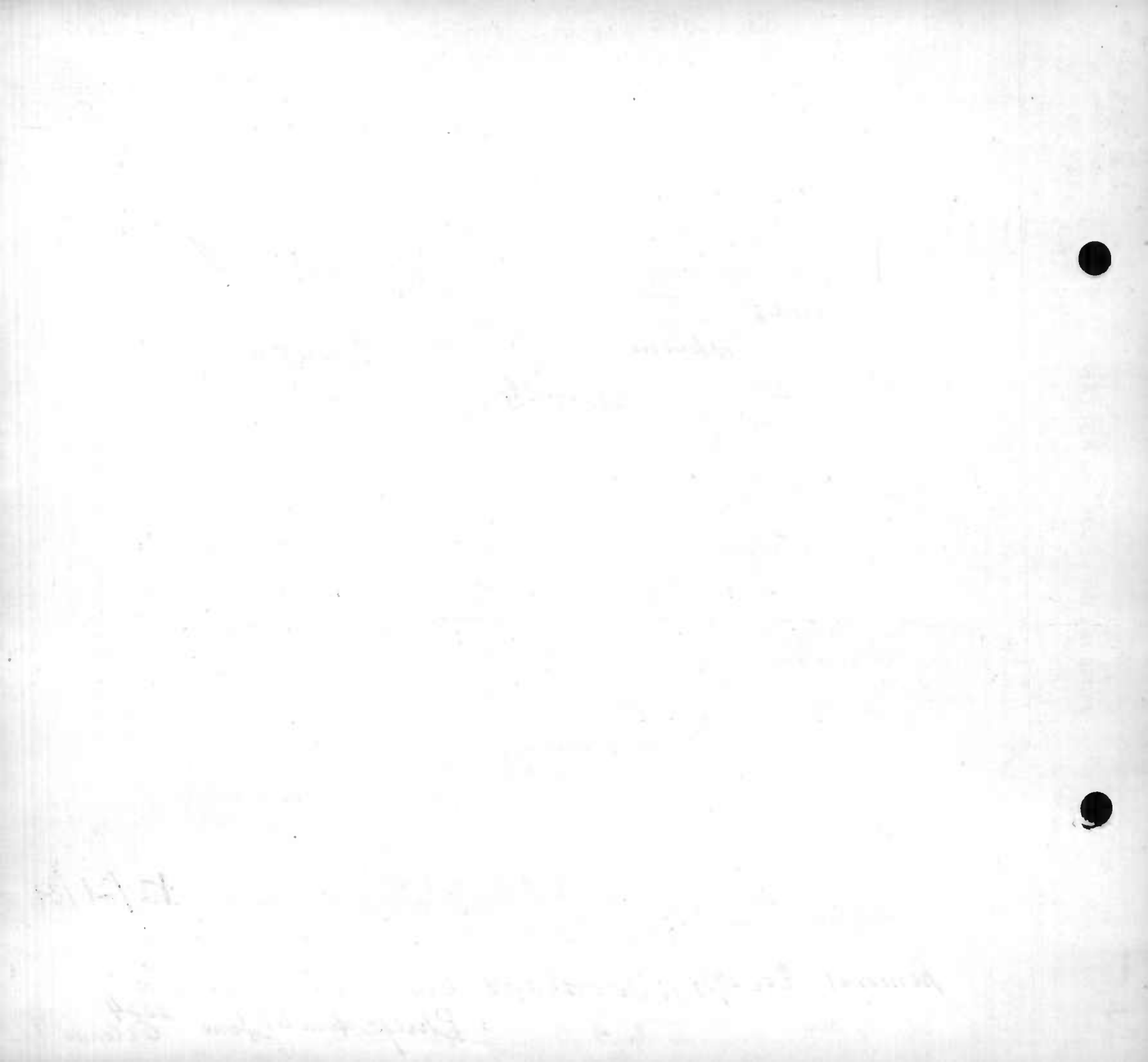
K-520 69 12971		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. 69 12971	
1. NAME OF DECEASED (Type or Print) <b>FRANK A KING</b>		2. DATE AND HOUR OF DEATH <b>12-27-69 8 55/A.M.</b>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>MARYLAND GENERAL HOSPITAL</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>Balt Co.</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>CATONSVILLE</b> D. STREET ADDRESS (If rural, give location) <b>118 LOCUST DR</b>			
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>WIDOWED</b>	8. DATE OF BIRTH <b>2-23-89</b>	9. AGE (In years lost birthday) <b>80</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>ELECTRICAL CONTRACTOR</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>ELECTRICAL</b>		11. BIRTHPLACE (State or foreign country) <b>BALTO.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>FRANK A. KING</b>		14. MOTHER'S MAIDEN NAME <b>MARY MORAN</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>216-32-6661</b>		17. INFORMANT <b>MRS. FORTHUBER</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>410.0 I Myocardial Infarction</b>		CAUSE OF DEATH <b>Generalized Atherosclerosis</b>		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) DUE TO		(B) <b>Atherosclerotic Heart disease</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>Nephrosclerosis obstructive uropathy urinary tract infection</b>		(C) DUE TO			
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>YES</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (H) (this hospital) attended the deceased from <b>11-24-1969</b> to <b>12-27-1969</b> , that (H) (we) last saw the deceased alive on <b>12-27-1969</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (H) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Salvatore R. Donohue</b>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>12-27-69</b>	
23C. PHYSICIAN'S NAME (Type) <b>SALVATORE R. DONOHUE</b>		23D. ADDRESS <b>MARYLAND GENERAL HOSP.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>	24B. DATE <b>12-30-69</b>	24C. NAME OF CEMETERY or CREMATORY <b>LODGE PARK CEMETERY</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 31 1969</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor, M.D.</b>		25C. FUNERAL DIRECTOR <b>Top City-Brooks-Tolson, Inc.</b>	
				ADDRESS <b>1050 YORK Rd. Towson, Md.</b>	



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J-525 69 12972		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 69 12972	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) JOHNSON, Con		2. DATE AND HOUR OF DEATH 12/21/69 7:15 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE B. COUNTY West Virginia V-45			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) The Johns Hopkins Hospital 33		C. CITY OR TOWN		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER			
5. SEX Male	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/25/92	9. AGE (In years lost birthday) 76 88	10. Under 1 Yr. Months Days If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME Johnson		14. MOTHER'S MAIDEN NAME Duncan	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 55 236-26-28		17. INFORMANT ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH Cardiogenic shock Septic emboli to brain Subphrenic abscess		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Probable occult malignancy					
19A. DATE OF OPERATION 11/18	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED wt loss & abd mass	20A. AUTOPSY? (Yes or No) Yes	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? No		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) No	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 12/1 1969 to 12/20 1969, that (I) (we) last saw the deceased alive on 12/20 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE H. J. Fee Jr.		23B. DATE SIGNED 12/24/69			
23C. PHYSICIAN'S NAME (Type) H. J. Fee Jr.		23D. ADDRESS Reed Hall JHH			
24A. BURIAL CREMATION, REMOVAL (Specify) Removal	24B. DATE Dec 23/69	24C. NAME OF CEMETERY or CREMATORY Woodland Cem	24D. LOCATION (City, town, or county) (State) Auto W. Va		
25A. DATE REC'D BY HEALTH DEPT. DEC 31 1969	25B. NAME OF REGISTRAR Philip Herwig	25C. FUNERAL DIRECTOR Philip Herwig	25D. ADDRESS Cileand		



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P-620		69 12973		BALTIMORE CITY HEALTH DEPARTMENT		69 12973	
BIRTH NO.				REG. NO.			
1. NAME OF DECEASED (Type or Print) <u>M. Kenneth PEARCE</u>				2. DATE AND HOUR OF DEATH <u>12-29-69</u> <u>8:35 A.M.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>BALTIMORE</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>NORTH CHARLES GEN. HOSP.</u> <u>49</u>				C. CITY OR TOWN <u>CITY</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				E. STREET AND NUMBER <u>1401 W. 36th St. Balt. Md.</u>			
5. SEX <u>MALE</u>	6. RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/13/09</u>	9. AGE (In years last birthday) <u>60</u>	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Stationary Engineer</u>			10B. KIND OF BUSINESS OR INDUSTRY <u>J. Hopkins Un.</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>Marion A. Pearce</u>				14. MOTHER'S MAIDEN NAME <u>Carrie Fisher</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO. <u>220-30-2877</u>		17. INFORMANT <u>Mildred M. Pearce</u>		
			ADDRESS <u>1401 W. 36th St.</u>				
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <u>157.9 + 1 250.9</u> (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH <u>Pulmonary embolism</u> <u>Cerebrovascular accident</u> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Massive myocardial infarction</u> (B) <u>Diabetes mellitus</u> DUE TO, OR AS A CONSEQUENCE OF: <u>Ca Pancreas</u> (C) <u>Diabetes mellitus</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Days</u> <u>Weeks</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>Yes</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>Yes</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>12-17</u> 19 <u>69</u> to <u>12/29/69</u> 19 <u>69</u> that (I) (we) last saw the deceased alive on <u>12-29/69</u> 19 <u>69</u> and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Frank V. Patricio</u>				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>12-29-69</u>	
23C. PHYSICIAN'S NAME (Type) <u>Frank V. PATRICIO</u>				23D. ADDRESS <u>MCCG</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>1/2/70</u>		24C. NAME of CEMETERY or CREMATORY <u>Sater's Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore Co. Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>DEC 31 1969</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor</u>		25C. FUNERAL DIRECTOR ADDRESS <u>Ann Donovan - 3818 Roland Ave.</u>			





# FUNERAL DIRECTOR: IMPORTANT

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L-251		S-120		69 12974		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 69 12974	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)	
		FLORENCE M. LAZENBY - Skaves		12-28-69 6 P.M.				A. STATE B. COUNTY Maryland	
FULL NAME OF HOSPITAL OR INSTITUTION		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN		D. INSIDE CITY LIMITS?			
37 Mercy Hospital				Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
5. SEX		6. RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)	
F		W				Mar. 29, 1907		62	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?			
Seamstress		Clothing		West Virginia		U.S.A.			
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
Henry Clay Bennett		Ethel Shook		No		214-16-2080		21223 Gladys O'Leary 2426 Wilkens Avenue	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		Cardiac Arrest					
ANTECEDENT CAUSES		(B) DUE TO, OR AS A CONSEQUENCE OF:		myocardial infarction					
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) Diabetes							
II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
0									
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?					
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>							
22. I certify that (I) (the hospital) attended the deceased from Dec. 28 1969 to Dec. 28 1969		that (I) (we) last saw the deceased alive on Dec. 28 1969 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE		23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
Young HEZ LIM				Young HEZ LIM					
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY		24D. LOCATION (City, town, or county) (State)			
Burial		12-31-69		Mount Olivet Cemetery		Baltimore, Maryland			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		25D. ADDRESS			
DEC 31 1969		Walters		Walters		Funeral Home Pratt & Stricker		Sts.	

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

H-555		69 12975		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 69 12975	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) <i>Henneman Nannie</i> (Nannie)			
2. DATE AND HOUR OF DEATH <i>12-27/69</i> <i>11 a.m.</i>							
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <i>Sinai Hospital of Baltimore</i>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>Belvedere &amp; Greenleaf Ave. Baltimore 21215 Md.</i>		A. STATE <i>Windor Nursing Home Baltimore</i>		B. COUNTY	
C. CITY OR TOWN <i>Baltimore</i>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		E. STREET AND NUMBER <i>3025 Windor Ave 15 47</i>			
5. SEX <i>MX F.</i>	6. RACE <i>W.</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>11-9/80</i>	9. AGE (in years last birthday) <i>89</i>	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Unknown</i>				14. MOTHER'S MAIDEN NAME <i>Unknown</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>None</i>		17. INFORMANT <i>Amelia Cilento</i>		ADDRESS <i>2806 Halcyon Ave.</i>	
18. <i>412.41E887</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>Ex Rt. Hip.</i>				CAUSE OF DEATH (A) IMMEDIATE CAUSE <i>A.S.C.V.D.</i> DUE TO, OR AS A CONSEQUENCE OF: (B) <i>Ex Rt. Hip.</i> DUE TO, OR AS A CONSEQUENCE OF: (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <i>12-17/69</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Ex Rt. Hip.</i>		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <i>yes</i>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <i>Windor Nursing H.</i>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <i>3025 Windor Ave 15 47</i>			
21D. TIME OF INJURY (APPROX.) <i>12 16 - 69</i>		21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? <i>fell</i>			
22. I certify that (I) (this hospital) attended the deceased from <i>12-16-1969</i> to <i>12-27-1969</i> that (I) (we) last saw the deceased alive on <i>12-27-1969</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>9059 J. Banderas M.D.</i>				23B. DATE SIGNED <i>12-27/69</i>			
23C. PHYSICIAN'S NAME (Type) <i>JULIO BANDERAS M.D.</i>				23D. ADDRESS <i>Sinai Hospital of Baltimore.</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>12/31/69</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Loudon Park Cem.</i>		24D. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>DEC 31 1969</i>		25B. NAME OF REGISTRAR <i>Robert C. Altenburg</i>		25C. FUNERAL DIRECTOR <i>Robert C. Altenburg Funeral Home, Inc.</i>		ADDRESS <i>6009 Harford Road Balto., Md. 21214</i>	

3025 Windsor Ave.

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

W-630		69 12976		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 69 12976	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) <b>MARIE I. WARD</b>			
2. DATE AND HOUR OF DEATH <b>12-28-69 11:30 A.M.</b>				3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			
4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>2734</b>				FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>UNION MEMORIAL HOSPITAL</b> <b>44</b>			
C. CITY OR TOWN <b>BALTIMORE</b>				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
E. STREET AND NUMBER <b>5419 PENBROOK AVENUE</b>				5. SEX <b>F</b> 6. RACE <b>W</b> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH <b>1-08-04</b> 9. AGE (in years last birthday) <b>65 yr.</b>				10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HSWE</b>			
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>				12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>Henry Kelley</b>				14. MOTHER'S MAIDEN NAME <b>Mary Collins</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>CHART</b>			
17. INFORMANT <b>CHART</b>				ADDRESS			
18. <b>199.0 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) IMMEDIATE CAUSE <b>Respiratory &amp; Cardiac Arrest</b> DUE TO, OR AS A CONSEQUENCE OF: (B) <b>Generalized carcinomatosis</b> DUE TO, OR AS A CONSEQUENCE OF: (C) _____			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION <b>12-27-69</b>				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			
20A. AUTOPSY? (Yes or No) <b>No</b>				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>12/26</b> 19 <b>69</b> to <b>12/28</b> 19 <b>69</b> that (I) (we) last saw the deceased alive on <b>12/28</b> 19 <b>69</b> and that (in my) (our) apntn death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				23A. SIGNATURE <b>[Signature]</b> <b>M.D.</b> DEGREE			
23B. DATE SIGNED <b>12/28/69</b>				23C. PHYSICIAN'S NAME (Type) <b>CARLOS E. FOSSI</b> <b>M.D.</b> DEGREE			
23D. ADDRESS <b>UNION MEMORIAL Hospital</b>				24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			
24B. DATE <b>12/31/69</b>				24C. NAME OF CEMETERY OR CREMATORY <b>Loudon Park</b>			
24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>				25A. DATE REC'D BY HEALTH DEPT. <b>DEC 31 1969</b>			
25B. NAME OF REGISTRAR <b>[Signature]</b>				25C. FUNERAL DIRECTOR <b>Robert C. Altenburg Funeral Home, Inc.</b>			
25D. ADDRESS <b>6009 Harford Road Balto., Md. 21214</b>				VS 150-REV. 1/1/68			

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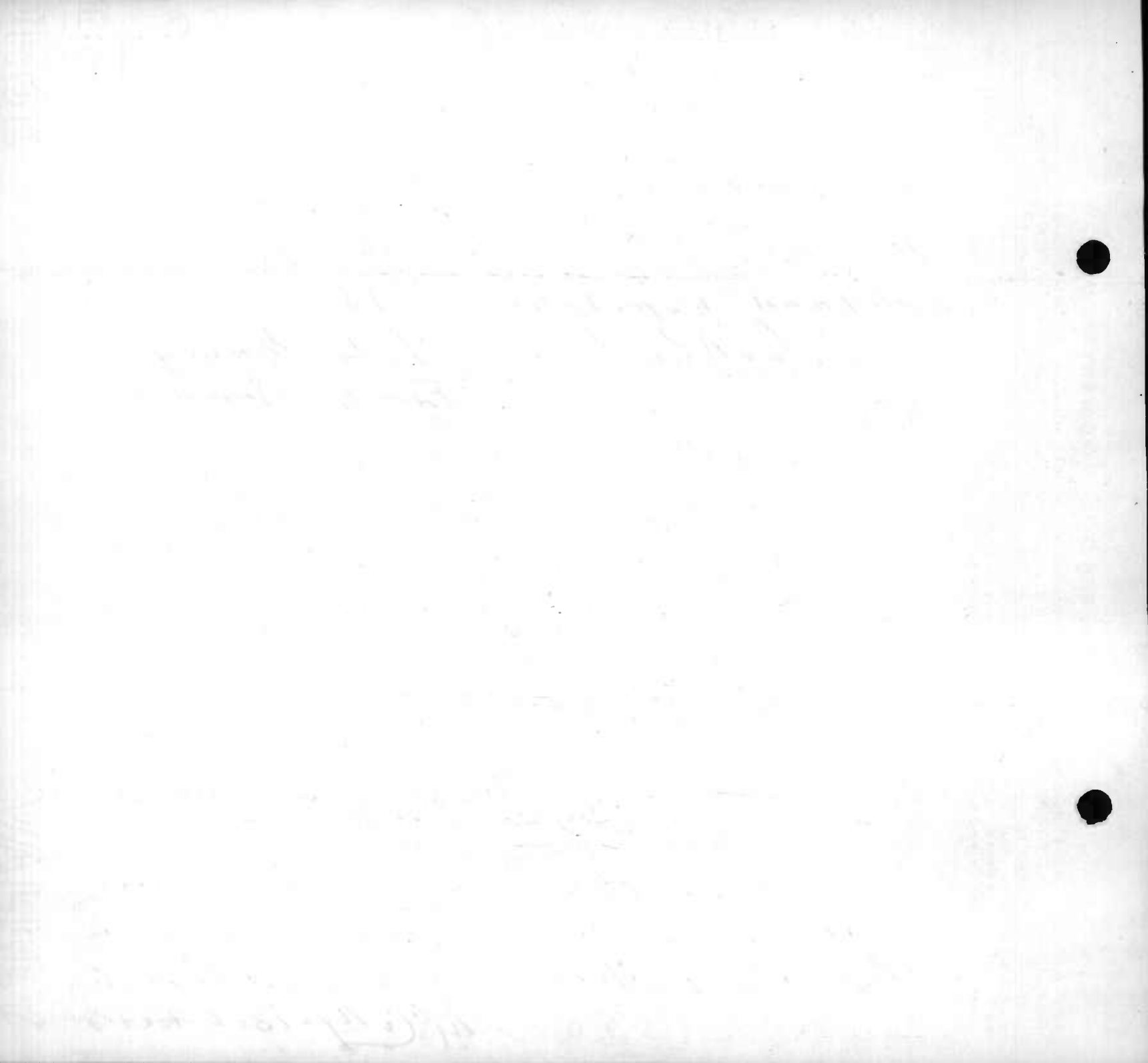


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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

M-410		69 12977		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 69 12977	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) <i>OTIS C. MILBY</i>			
2. DATE AND HOUR OF DEATH <i>12-27-69 8:15 A.M.</i>				3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			
FULL NAME OF HOSPITAL OR INSTITUTION <i>0109 WALKER HOS.</i>				(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			
4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>MD.</i> B. COUNTY <i>2403</i>				C. CITY OR TOWN <i>BALTO.</i> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
E. STREET AND NUMBER <i>109 WALKER ASS.</i>							
5. SEX <i>M</i>	6. RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>8-8-26</i>	9. AGE (In years last birthday) <i>43</i>	If Under 1 Yr. Months: Days:	If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>WATCHMAN</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>WELFARE HOUSE</i>		11. BIRTHPLACE (State or foreign country) <i>VA.</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>Jackson L.</i>				14. MOTHER'S MAIDEN NAME <i>Lula Massey</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>NO</i>				16. SOCIAL SECURITY NO.		17. INFORMANT <i>FAMILY - SAME</i> ADDRESS	
18. <i>412.21</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Arteriosclerosis &amp; Hypertensive Cardiovascular Disease</i> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) <i>Paralysis of legs lower extremities due to Arteriosclerosis &amp; Hypertensive Cardiovascular Disease</i>			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>NO</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>Dec 3, 1967</i> to <i>Dec 27, 1969</i> , that (I) (we) last saw the deceased alive on <i>Dec 29, 1969</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
23A. SIGNATURE <i>H.P. Friedman</i> M.D.				23B. DATE SIGNED <i>12/27/69</i>			
23C. PHYSICIAN'S NAME (Type) <i>H.P. FRIEDMAN</i> M.D.				23D. ADDRESS <i>1317 LIGHT ST. BALTIMORE MD. 21230</i>			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <i>12/31/69</i>		24C. NAME OF CEMETERY or CREMATORY <i>WILMINGTON GORE</i>		24D. LOCATION (City, town, or county) (State) <i>WEST POINT, VA</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>DEC 31 1969</i>		25B. NAME OF REGISTRAR <i>Robert E. Taylor</i>		25C. FUNERAL DIRECTOR <i>W.C. City</i>		ADDRESS <i>130 E. Fort Ave.</i>	





FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

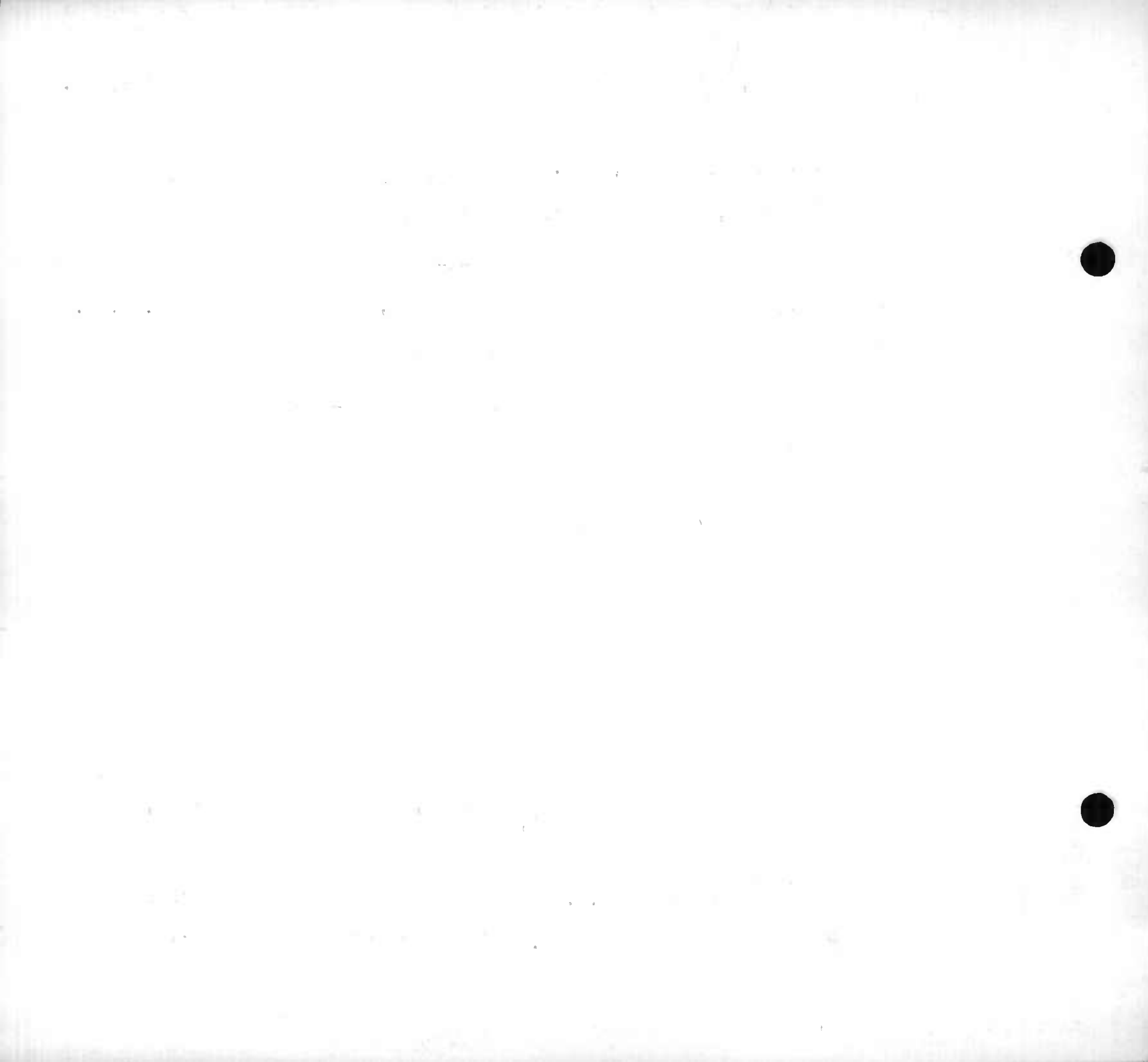
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="background-color: black; color: black;">[REDACTED]</span>	
G-416		69 12978		CERTIFICATE OF DEATH	
BIRTH NO. <span style="background-color: black; color: black;">[REDACTED]</span>		69 12978		4:55 P.M.	
1. NAME OF DECEASED (Type or Print) <b>GULBRETH GEORGE</b>		2. DATE AND HOUR OF DEATH <b>12/29/69</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>HARBOR VIEW N.C.C.</b>		4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE <b>MD</b> B. COUNTY <b>Balti.</b>		15 01	
5. SEX <b>Male</b> 6. RACE <b>Negro</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>8/12/05</b> 9. AGE (In years last birthday) <b>63</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>PLASTICS</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>PLASTIC</b>		11. BIRTHPLACE (State or foreign country) <b>N.C.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>SIDNEY</b>		14. MOTHER'S MAIDEN NAME <b>MAMIE McDONALD</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>240-18-1258</b>		17. INFORMANT <b>Chart</b> ADDRESS	
18. <b>412.21</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Cardiac Arrest</b>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>A.S.C.V. Disease</b> (B) DUE TO, OR AS A CONSEQUENCE OF: <b>Hypertension</b> (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A):					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>4/12</b> <b>1969</b> to <b>12/29</b> <b>1969</b> , that (I) (we) last saw the deceased alive on <b>12/28</b> <b>1969</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Joseph S. Blum M.D.</b>		23B. DATE SIGNED <b>12/30/69</b>			
23C. PHYSICIAN'S NAME (Type) <b>JOSEPH S. BLUM MD</b>		23D. ADDRESS <b>1115 N. CALVERT ST.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1/3/70</b>		24C. NAME OF CEMETERY or CREMATORY <b>Fayetteville</b>	
24D. LOCATION (City, town, or county) <b>North Carolina</b>					
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 31 1969</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor M.D.</b>		25C. FUNERAL DIRECTOR <b>Adolphus Halstead</b> ADDRESS <b>1206 W north Av</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <span style="float: right;">69 12979 7</span>	
C-400 69 12979		CERTIFICATE OF DEATH	
BIRTH NO. <u>6922372</u>		1. NAME OF DECEASED (Type or Print) <u>Clay, Baby of Joan</u>	
2. DATE AND HOUR OF DEATH <u>12/6/69</u> <u>1:55 p.</u> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION <u>39</u>		A. STATE <u>Maryland</u> B. COUNTY <u>1301</u>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Provident Hospital, Inc.</u> <u>1514 Division Street</u> <u>Baltimore, Maryland 21217</u>		C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <u>2521 Brookfield Avenue</u>			
5. SEX <u>Female</u>	6. RACE <u>Newgro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-6-69</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Minor (infant)</u>		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (in years last birthday) <u>4</u> <u>44</u> If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Herbert Gault</u>		14. MOTHER'S MAIDEN NAME <u>Joan Mozell Clay</u>	
15. Was Deceased Ever in U. S. Armed Forces? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT <u>Miss Joan Clay- mother</u>
		ADDRESS <u>SAME</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <u>Cardio-respiratory Failure</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Immaturity in Development</u>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) <u>Immaturity in Development</u> DUE TO, OR AS A CONSEQUENCE OF: (C) _____	
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>4-5 hrs.</u>			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) <u>No</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>December 6, 1969</u> to <u>December 6, 1969</u> that (I) (we) lost saw the deceased alive on <u>December 6, 1969</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <u>Desideria T. Mahoney, M.D.</u>		23B. DATE SIGNED <u>12-9-69</u>	
23C. PHYSICIAN'S NAME (Type) <u>M.D.</u>		23D. ADDRESS <u>1514 Division Street Balto., Maryland 21217</u>	
24A. BURIAL CREMATION REMOVAL (Specify) <u>12-18-69</u>		24B. DATE	
24C. NAME OF CEMETERY		24D. LOCATION (City, town, or county) (State)	
25A. DATE REC'D BY HEALTH DEPT. <u>DEC 31 1969</u>		25B. NAME OF REGISTRAR <u>Robert E. Mahoney</u>	
25C. FUNERAL DIRECTOR <u>MORTUARY SERVICE - BCHD</u>		ADDRESS	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

S-530 BIRTH NO. 69-123430 69 12980		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 69 12980 ✓	
1. NAME OF DECEASED (Type or Print) <i>Smoet Baby Girl</i>		2. DATE AND HOUR OF DEATH <i>Dec. 17 '69 18:15 PM M.</i>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <i>Sinai Hospital of Baltimore</i>		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <i>Md.</i> B. COUNTY <i>2717</i>			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>Sinai Hospital of Baltimore</i>		C. CITY OR TOWN <i>Baltimore</i>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <i>Female</i>		6. RACE <i>Negro</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH <i>11:15 PM, Dec. 16</i>	
11. BIRTHPLACE (State or foreign country)		9. AGE (in years last birthday) <i>49 1/2</i>		12. CITIZEN OF WHAT COUNTRY? <i>Quinnipiac Ark</i>	
13. FATHER'S NAME <i>UNKNOWN</i>		14. MOTHER'S MAIDEN NAME <i>Juanita</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
18. <i>776.1 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Possible Hyaline Membr. Dis.</i> (B) <i>Premature</i> DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>Dec. 16</i> 19 <i>69</i> to <i>Dec. 17</i> 19 <i>69</i> . that (I) (we) last saw the deceased alive on <i>8:05 PM, Dec. 17, 19 69</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Tokum e. Oz</i>		23B. DATE SIGNED <i>Dec. 17 '69</i>		23C. PHYSICIAN'S NAME (Type) <i>HYUN TAIK OH</i>	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <i>12-22-69</i>		24C. NAME OF CEMETERY or CREMATOR <i>JOHNS HOPKINS MEDICAL SCHOOL MORTUARY SERVICE - BCHD</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>DEC 31 1969</i>		25B. NAME OF REGISTRAR <i>Robert E. Taylor, Jr.</i>		25C. FUNERAL DIRECTOR <i>JOHNS HOPKINS MEDICAL SCHOOL MORTUARY SERVICE - BCHD</i>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		X REG. NO. 69 12981	
C-452 69 12981		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <b>ELMER PATRICK COLLINS</b>		2. DATE AND HOUR OF DEATH <b>12/15/69 3:20 A.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MD</b> B. COUNTY <b>Howard Co.</b>	
FULL NAME OF HOSPITAL OR INSTITUTION <b>38 UNIVERSITY</b>		C. CITY OR TOWN <b>JESSUP</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
E. STREET AND NUMBER		5. SEX <b>M</b> 6. RACE <b>W</b>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>5/22/29</b> 9. AGE (In years last birthday) <b>40</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>MD</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>WILLIAM</b>		14. MOTHER'S MAIDEN NAME <b>MARGARET MORAN</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT		ADDRESS	
18. <b>2250</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) IMMEDIATE CAUSE <b>BRAIN TUMOR</b> DUE TO, OR AS A CONSEQUENCE OF: (B) _____ DUE TO, OR AS A CONSEQUENCE OF: (C) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>6 weeks</b>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			
19A. DATE OF OPERATION <b>1/14/69</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>BRAIN TUMOR</b>	
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <b>NO</b>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I certify that (1) (this hospital) attended the deceased from <b>12/14/69</b> 19 to <b>12/15/69</b> 19 that (1) (we) last saw the deceased alive on <b>12/14/69</b> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <b>Fred N. Sugar</b>		23B. DATE SIGNED <b>12/15/69</b>	
23C. PHYSICIAN'S NAME (Type) <b>FRED N. SUGAR</b>		23D. ADDRESS <b>UNIVERSITY MEDICAL SCHOOL</b>	
24A. BURIAL CREMATION REMOVAL (Specify)		24B. DATE <b>12-23-69</b>	
24C. NAME OF CEMETERY <b>ANATOMY BOARD OF MARYLAND</b>		24D. LOCATION (City, town, or county) (State)	
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 31 1969</b>		25B. NAME OF REGISTRAR <b>Robert E. [Signature]</b>	
25C. FUNERAL DIRECTOR <b>MORTUARY SERVICE - BCHO</b>		ADDRESS	





This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

P-620		69 12982		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 69 12982	
BIRTH NO.				DATE AND HOUR OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>Pierce, Martha</b>				12-15-69 9:20 a. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>1701</b>			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>Provident Hospital, Inc. 1514 Division Street Baltimore, Maryland 21217</b>				C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <b>505 Pennsylvania Avenue</b>			
5. SEX <b>Female</b>	6. RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2-2-90</b>	9. AGE (In years last birthday) <b>72</b>	If Under 1 Yr. Months: Days: Hours: Min.	If Under 24 Hrs. Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Unemployed</b>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>North Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mr. M. Joseph Pierce (Son)</b> ADDRESS <b>same</b>		
18. <b>412.2 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>CONGESTIVE HEART FAILURE</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>CONGESTIVE HEART FAILURE</b> (B) <b>HYPERTENSIVE CARDIOVASCULAR DISEASE</b> DUE TO, OR AS A CONSEQUENCE OF: <b>ARTEROSCLEROSIS</b> (C) <b>GEN</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>11-28-69</b> 19 to <b>12-15-69</b> 19 that (I) (we) last saw the deceased alive on <b>12-15-69</b> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>G. Tengco M.D.</b>				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>12-15-69</b>	
23C. PHYSICIAN'S NAME (Type) <b>G. Tengco M.D.</b>				23D. ADDRESS <b>Provident Hospital, Inc. 1514 Division Street Baltimore, Maryland</b>			
24A. BURIAL CREMATION REMOVAL (Specify)		24B. DATE <b>12-18-69</b>		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 31 1969</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor, M.D.</b>		25C. FUNERAL DIRECTOR <b>MORTUARY SERVICE - BCHD</b>			



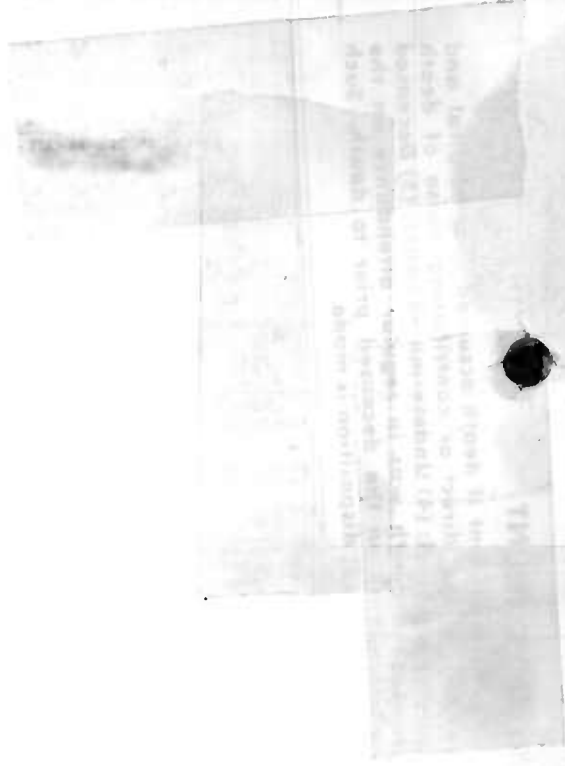
MEDICAL EXAMINER APPROVAL

## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital, and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-520		69 12983		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		REG. NO. 69 12983	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) <b>BUNCE, CLAYTON</b>				2. DATE AND HOUR OF DEATH <b>12-19-69 1:50 PM</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>BALTO. CO.</b> B. COUNTY <b>5300</b>				M.	
FULL NAME OF HOSPITAL OR INSTITUTION <b>425/NAI HOSPITAL of BALTO.</b>				C. CITY OR TOWN <b>BALTO.</b>				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <b>M</b>				6. RACE <b>W</b>				7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <b>7/9/87</b>				9. AGE (in years last birthday) <b>82</b>				10. UNDER 1 Yr. Months: Days: Hours: Min.	
11. BIRTHPLACE (State or foreign country)				12. CITIZEN OF WHAT COUNTRY?					
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.				17. INFORMANT ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <b>ACUTE RENAL FAILURE</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 week.</b>					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>POST RENAL OBSTRUCTION</b>				DUE TO, OR AS A CONSEQUENCE OF: <b>10 days.</b>					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>INTERTROCHANTERIC HIP FRACTURE</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>20 days.</b>					
19A. DATE OF OPERATION <b>11-30-69</b>				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>(L) HIP FRACTURE</b>				20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>NURSING HOME</b>				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>BENT NURSING HOME</b>	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx) <b>11-30-69</b>				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>				21F. HOW DID INJURY OCCUR? <b>Fell on (L) HIP</b>	
22. I certify that (this hospital) attended the deceased from <b>11-30-69</b> 19 to <b>12-19-69</b> 19				that (we) last saw the deceased alive on <b>12-19-69</b> 19 and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>M. Bodenheimer</b>				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED <b>12-19-69</b>	
23C. PHYSICIAN'S NAME (Type) <b>M. Bodenheimer</b>				23D. ADDRESS <b>Sinai Hospital</b>					
24A. BURIAL CREMATION, REMOVAL (Specify) <b>12-22-69</b>				24B. DATE <b>12-22-69</b>				24C. NAME OF CEMETERY or INTERMENT PLACE <b>JOHNS HOPKINS MEDICAL SCHOOL MORTUARY SERVICE - BCHD</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 31 1969</b>				25B. NAME OF REGISTRAR <b>Jacob E. [Signature]</b>				25C. FUNERAL DIRECTOR ADDRESS	

Don't know



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

69 12984 CERTIFICATE OF DEATH

REG. NO. 69 12984

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>MOLLIE CHASE</b>		2. DATE AND HOUR OF DEATH <b>12/30/69 12 noon PM.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION <b>2521 Guilford ave.</b>			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MD</b> B. COUNTY <b>1203</b>		
5. SEX <b>F.</b> 6. RACE <b>Negro</b> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH <b>Oct. 7, 1899</b> 9. AGE (In years last birthday) <b>70</b>		10. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Va.</b>
13. FATHER'S NAME <b>Robert E. Harris</b>			14. MOTHER'S MAIDEN NAME <b>Elena Robinson</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>			16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT <b>Paul Montoya</b> ADDRESS <b>2521 Guilford ave</b>
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>412.2 I Congestive heart failure</b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>HASCVD &amp; CVA.</b> (B) DUE TO, OR AS A CONSEQUENCE OF: (C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>Jan 19 1967</b> to <b>Dec. 30 19 69</b> , that (I) (we) last saw the deceased alive on <b>Dec 30 19 69</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Benigno R. Lazaro</b>				23B. DATE SIGNED <b>12-30-69</b>	
23C. PHYSICIAN'S NAME (Type) <b>BENIGNO R. LAZARO MD</b>				23D. ADDRESS <b>59 Dundalk ave. Balto Md 21222</b>	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
<b>Burial</b>		<b>1/5/70</b>		<b>mt. Auburn Balto. Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>DEC 31 1969</b>		25B. NAME OF REGISTRAR <b>Robert E. Taber</b>		25C. FUNERAL DIRECTOR <b>Howard Whitman Jr.</b> ADDRESS <b>1701 Mc. Allister St. Balto. Md.</b>	

251 Highland Ave

Oct 8 1881

W. B.

Chicago, Ill.

Dear Sir,

251 Highland Ave

F. W. B.

Chicago, Ill.

Dear Sir,

Yours

Yours

W. B.

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<b>W-220</b> <b>69 12985</b> <b>BALTIMORE CITY HEALTH DEPARTMENT</b> <b>(WASKIEWICZ)</b> <b>CERTIFICATE OF DEATH</b> <b>REG. NO. 69 12985</b>			
<b>BIRTH NO.</b> 1. NAME OF DECEASED (Type or Print) <b>SABINA S. WASZKIEWICZ</b>		<b>2. DATE AND HOUR OF DEATH</b> <b>12/29/69 5:25 P.M.</b>	
<b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b> <b>MARYLAND General Hospital</b>		<b>4. USUAL RESIDENCE (Where deceased lived, if institutions residence before admission)</b> <b>A. STATE Md. &amp; COUNTY ST. MD.</b> <b>C. CITY OR TOWN BALTO</b> <b>D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></b> <b>E. STREET AND NUMBER 2010 Portugal St. 21231</b>	
<b>5. SEX F</b> <b>6. RACE W</b> <b>7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/></b>	<b>8. DATE OF BIRTH 12-27-86</b> <b>9. AGE (in years lost birthday) 83</b>	<b>10. A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SEW. MACHINE OPER.</b> <b>10B. KIND OF BUSINESS OR INDUSTRY HOWARD UNIFORM</b> <b>11. BIRTHPLACE (State or foreign country) Poland</b> <b>12. CITIZEN OF WHAT COUNTRY? POLAND</b>	
<b>13. FATHER'S NAME ALOJZEGO SZYPULSKI</b> <b>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO</b>		<b>14. MOTHER'S MAIDEN NAME JULIANA WASOWSKI</b> <b>16. SOCIAL SECURITY NO. 2 16 07 435</b> <b>17. INFORMANT STANLEY WASKIEWICZ ADDRESS 3504 NORTHWAY DR. 21234</b>	
<b>18. 412.41 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		<b>CAUSE OF DEATH</b> <b>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Pneumonia</b> <b>Arteriosclerotic Cardiovascular Disease (ASCVD)</b> <b>(B) DUE TO, OR AS A CONSEQUENCE OF:</b> <b>(C) DUE TO, OR AS A CONSEQUENCE OF:</b>	
<b>19. 412.41 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).</b>		<b>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 36 hrs</b>	
<b>19A. DATE OF OPERATION</b> <b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)</b>	<b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b> <b>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</b>	<b>20A. AUTOPSY? (Yes or No)</b> <b>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</b>	<b>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</b>
<b>21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx)</b>	<b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	<b>21F. HOW DID INJURY OCCUR?</b>	
<b>22. I certify that (I) (this hospital) attended the deceased from 12/28 1969 to 12/29 1969 that (I) (we) last saw the deceased alive on 12/29 1969 and that (I) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</b>			
<b>23A. SIGNATURE William L. Boddie MD</b> <b>23C. PHYSICIAN'S NAME (Type) William L. Boddie MD</b>		<b>23B. DATE SIGNED 12/29/69</b> <b>23D. ADDRESS Maryland General Hospital</b>	
<b>24A. BURIAL CREMATION, REMOVAL (Specify) Burial</b>	<b>24B. DATE 1/2/70</b>	<b>24C. NAME OF CEMETERY OR CREMATORY Sacred Heart of Mary</b>	<b>24D. LOCATION (City, town, or county) Balto. Co. MD. (State)</b>
<b>25A. DATE REC'D BY HEALTH DEPT. DEC 31 1969</b>	<b>25B. NAME OF REGISTRAR Robert E. Fisher, MD</b>	<b>25C. FUNERAL DIRECTOR W. J. Walkowski</b>	<b>ADDRESS 2007 Eastern</b>

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-516 69 12986				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 69 12986	
CERTIFICATE OF DEATH							
1. NAME OF DECEASED (Type or Print) <b>SINCLAIR BONAPARTE</b>				2. DATE AND HOUR OF DEATH <b>December 26, 1969</b> M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION <b>LUTHERAN HOSPITAL</b> (If not in hospital or institution, give street address or location)				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>1608</b>			
5. SEX <b>Male</b> 6. RACE <b>Negro</b> 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>Married</b>				8. DATE OF BIRTH <b>2-23-1908</b>		9. AGE (In years last birthday) <b>61</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>				10B. KIND OF BUSINESS OR INDUSTRY <b>Beth-Steel</b>		11. BIRTHPLACE (State or foreign country) <b>Jacksonville, Florida</b>	
13. FATHER'S NAME <b>Rutha <del>VXXXXX</del> Bonaparte</b>				14. MOTHER'S MAIDEN NAME <b>Emma Bonaparte</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>yes 10/10/42 11/5/45</b>				16. SOCIAL SECURITY NO. <b>218-10-4880</b>		17. INFORMANT <b>Mrs. Catherine Bonaparte</b> ADDRESS <b>Same</b>	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  19A. DATE OF OPERATION <b>10.9 + 1250.9</b> 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  20A. AUTOPSY? (Yes or No) <b>No</b> 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				DUE TO <b>Acute myocardial infarction</b> <b>30 min</b>		INTERVAL BETWEEN ONSET AND DEATH	
				DUE TO <b>Arteriosclerotic Heart Disease</b> <b>18 months</b>			
				DUE TO <b>Diabetic Insulin</b> <b>18 months</b>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>June 6</b> 19 <b>68</b> to <b>Dec 26</b> 19 <b>69</b> , that (I) (we) last saw the deceased alive on <b>Oct 30</b> 19 <b>69</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Roland T. Smoot</b> M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>				23B. DATE SIGNED <b>12/29/69</b>			
23C. PHYSICIAN'S NAME (Type) <b>ROLAND T. SMOOT</b>				23D. ADDRESS <b>2300 Sanian Blvd. Balto 21416</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12-30-69</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Baltimore Nat'l Cem.</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 2 1970</b>		25B. NAME OF REGISTRAR <b>Robert E. Galt</b>		25C. FUNERAL DIRECTOR ADDRESS <b>MORTON &amp; DYETT F.H. 1701 Laurens Street</b>			



F-425		69 12987		BALTIMORE CITY HEALTH DEPARTMENT		MEDICAL EXAMINER'S CERTIFICATE OF DEATH		REG. NO. 69 12987	
BIRTH NO.									
1. NAME OF DECEASED (Type or Print) <b>H. JAMES FALCON</b>					2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.				
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>43 South Baltimore General Hospital</b>					3. DATE PRONOUNCED DEAD Month Day Year Hour <b>12 28 69 8:55 P.M.</b>				
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)					5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>2542</b>				
6. SEX <b>Male</b>		7. RACE <b>Negro</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Balto.</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
9. DATE OF BIRTH <b>5-27-1907</b>		10. AGE (In years lost birthday) <b>62</b>		11. BIRTHPLACE (State or foreign country) <b>Warren Co. N.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		E. STREET AND NUMBER <b>634 Cheraton Road</b>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		14B. KIND OF BUSINESS OR INDUSTRY <b>Md. Cup Co.</b>		13. FATHER'S NAME <b>Albert Falcon</b>		15. MOTHER'S MAIDEN NAME <b>Annie Falcon</b>			
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (if yes, give war or dates of service) <b>No.</b>		17. SOCIAL SECURITY NO. <b>240-28-4533</b>		18. INFORMANT <b>Mrs. Bertha Falcon</b>		ADDRESS <b>634 Cheraton Road</b>			
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Arteriosclerotic cardiovascular disease</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). II 20A. DATE OF OPERATION 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED 21. AUTOPSY? (Yes or No) <b>no</b>									
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 22C. WHERE DID (if in Baltimore City, give exact location) INJURY OCCUR? 22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> 22F. HOW DID INJURY OCCUR?									
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE <b>Russell S. Fisher, M.D.</b> M.D. EXAMINER'S NAME (Type) DATE SIGNED <b>12-29-69</b>									
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1-2-70</b>		24C. NAME of CEMETERY or CREMATORY <b>Arbutus Memorial Pk</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 2 1970</b>				25B. NAME OF REGISTRAR <b>Robert E. Fisher, M.D.</b>		25C. FUNERAL DIRECTOR ADDRESS <b>MORTON &amp; DYETT F.H. 1701 Laurens</b>			

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

0-520		69 12988		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 69 12988	
<b>CERTIFICATE OF DEATH</b>							
BIRTH NO. 1. NAME OF DECEASED (Type or Print) <b>OWENS RUDOLPH.</b>				2. DATE AND HOUR OF DEATH <b>December 29, 1969 7:30 A.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>1512</b>			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>SINAI HOSPITAL OF BALTIMORE</b>				C. CITY OR TOWN <b>BALTIMORE</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <b>3722 Park Hgts #15</b>			
5. SEX <b>M</b>	6. RACE <b>C.</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <b>4/11/07</b>	9. AGE (In years last birthday) <b>62</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>laborer</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>BALTIMORE, Md</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Willie Owens</b>				14. MOTHER'S MAIDEN NAME <b>Grace Owens</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No.</b>		16. SOCIAL SECURITY NO. <b>215-16-4657</b>		17. INFORMANT <b>Mrs. Bernice Hyanson</b>		ADDRESS <b>3722 Park Hgts Ave</b>	
18. <b>410.91 x 199.0</b> CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				(A) IMMEDIATE CAUSE <b>POSSIBLE MYOC. INFARCTION</b>			
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)				DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES				(B) _____			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				DUE TO, OR AS A CONSEQUENCE OF:			
(C) _____							
<b>II</b>							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>METASTATIC ADENOCARCINOMA OF UNKNOWN ORIGIN.</b>							
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>11 / 5 1969</b> to <b>12 / 29 1969</b> that (I) (we) last saw the deceased alive on <b>12 / 29 1969</b> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE  M.D. - DEGREE						23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) <b>ANDREAS A. PETSAS</b>				23D. ADDRESS <b>SINAI HOSPITAL OF BALTIMORE.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1/2/70</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Mt. Auburn Cem.</b>		24D. LOCATION (City, town, or county) (State) <b>Balt. Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 2 1970</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR <b>MORTON E. DYETT F.H.</b>		ADDRESS <b>1701 Laurens St.</b>	

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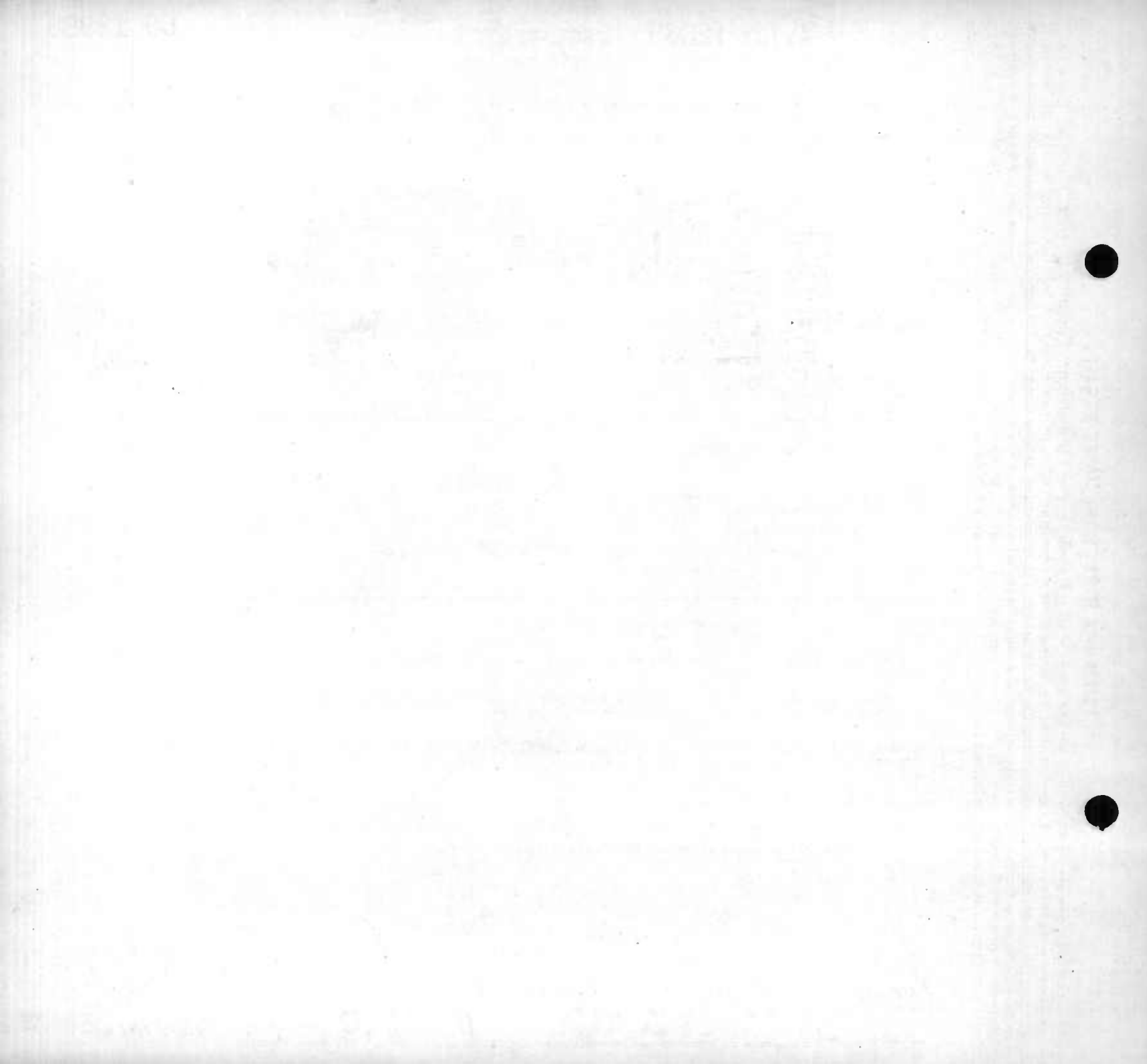
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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <b>S-530</b>		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <b>69 12989</b>	
1. NAME OF DECEASED (Type or Print) <b>SMITH, WILBUR</b>			2. DATE AND HOUR OF DEATH <b>12/29/69</b> <b>9<sup>45</sup> A M.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>1302</b>		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>LAKE DRIVE NURSING HOME</b> <b>2401 EUTAW PLACE</b> <b>BALTIMORE, MARYLAND 21217</b>			C. CITY OR TOWN <b>BALTIMORE</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
E. STREET AND NUMBER <b>2238 LINDEN AVE</b>					
5. SEX <b>M</b>	6. RACE <b>N</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	B. DATE OF BIRTH <b>1-8-09</b>	9. AGE (In years last birthday) <b>60</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>LABORER</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>-</b>	11. BIRTHPLACE (State or foreign country) <b>ATLANTA, GEORGIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>UNKNOWN (Richard Smith)</b>			14. MOTHER'S MAIDEN NAME <b>UNKNOWN (Cally Smith)</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>UNKNOWN</b>		16. SOCIAL SECURITY NO. <b>217-10-9919</b>	17. INFORMANT <b>Serge K Young R.N.</b> ADDRESS <b>Take Drive 2401 Eutaw Ave</b>		
18. <b>15791</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b> <b>Dementia of Pueria</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>12/23</b> 19 <b>69</b> to <b>12/29</b> 19 <b>69</b> , that (I) (we) last saw the deceased alive on <b>12/23</b> 19 <b>69</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>W. Robinson</b> M.D. OEGREE			23B. DATE SIGNED		Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>
23C. PHYSICIAN'S NAME (Type) <b>W. Robinson F. Robinson</b> OEGREE			23D. ADDRESS <b>7535 PIPERS PATH</b> <b>Rockville, Md</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>1-2-70</b>	24C. NAME OF CEMETERY or CREMATORY <b>Mt. Auburn Cem.</b>		24D. LOCATION (City, town, or county) <b>Baltimore, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 2 1970</b>		25B. NAME OF REGISTRAR <b>John E. Taylor, M.D.</b>		25C. FUNERAL DIRECTOR <b>Robert F. H. 1701 Laurens St</b>	





FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

A-6401

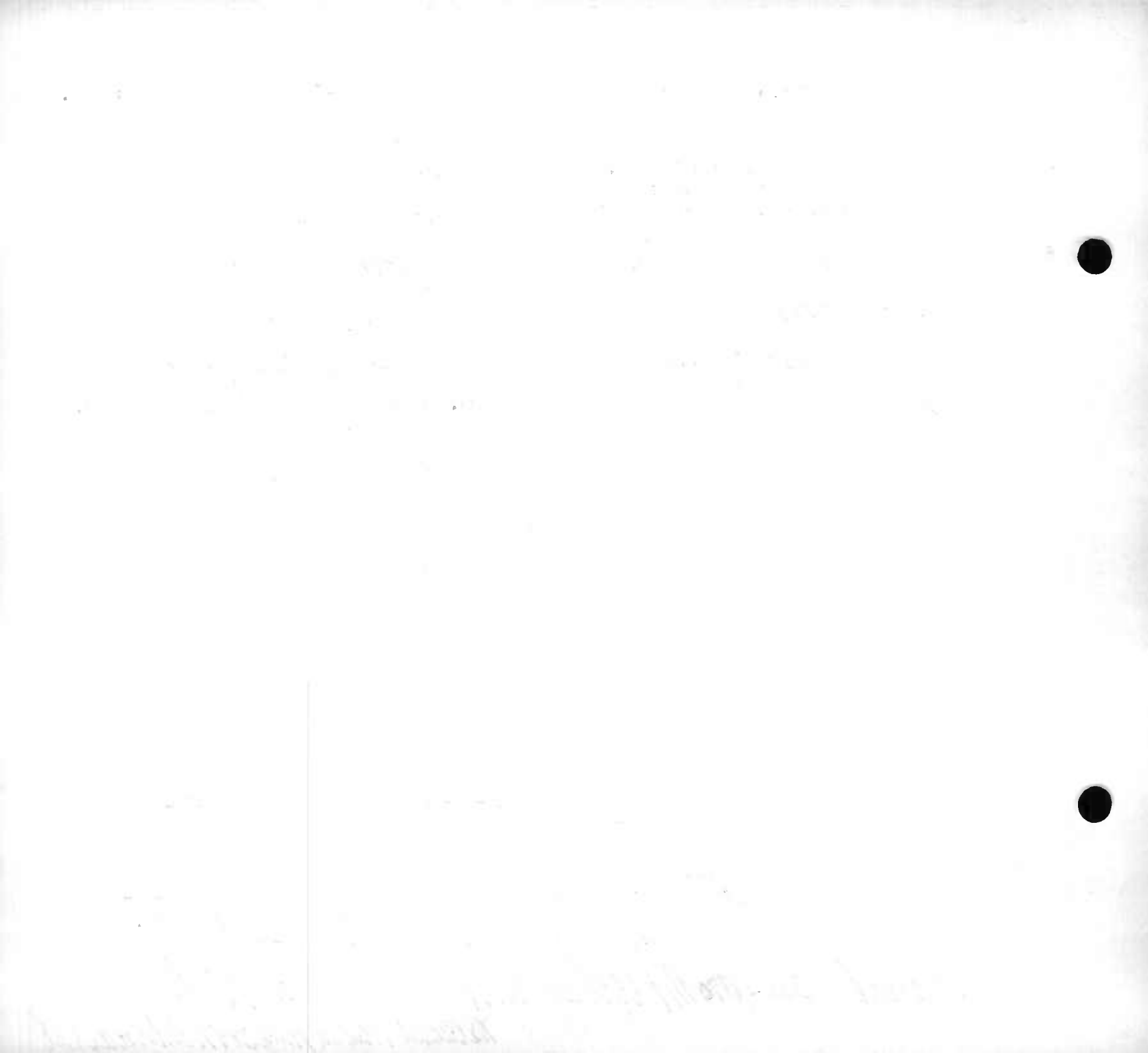
69 12990

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO.

69 12990

BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Harley, Florence		12-29-69 1:55 a. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE B. COUNTY	
39 Provident Hospital, Inc. 1514 Division Street Baltimore, Maryland 21217				Maryland 1601	
				C. CITY OR TOWN D. INSIDE CITY LIMITS?	
				Baltimore YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER				1124 Riggs Avenue	
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (in years last birthday)	10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
Female	Negro	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	Aug. 9, 1891	78	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Domestic				Cambridge Md.	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
Joseph Sampson			Josephine Sampson		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
NO		382-164160		Mrs. Marie Chisley 1124 Riggs Ave.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
412.21 Heart Failure					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
				Intracerebral Hemorrhage	
				(B) DUE TO, OR AS A CONSEQUENCE OF:	
				Hypertensive Cardiovascular disease	
				(C) DUE TO, OR AS A CONSEQUENCE OF:	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
				No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 12-24-69 19 to 12-29-69 19 that (I) (we) last saw the deceased alive on 12-29-69 19 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
G. TENOCO MD				12-29-69	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
		Provident Hospital, Inc. 1514 Division Street - Baltimore, Maryland			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY	
Burial		Jan 2, 1970		Mt Calvary Cms.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
JAN 2 1970		R. E. Barber, R.D.		William J. Young, 3197 Belvidere St.	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				69 12991	
69 12991				REG. NO. 69 12991	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Hawkins, Thomas E.		12-29-69 11:15 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION 39 IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION Provident Hospital 1514 Divison Street Baltimore, Maryland 21217			A. STATE Maryland		
			C. CITY OR TOWN Baltimore		
5. SEX Male			6. RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Herb's Lounge		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH 2-4-31	
13. FATHER'S NAME Herbert Hawkins		14. MOTHER'S MAIDEN NAME Mary Ebb		9. AGE (in years last birthday) 38	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes		16. SOCIAL SECURITY NO.		11. BIRTHPLACE (State or foreign country) Baltimore	
				12. CITIZEN OF WHAT COUNTRY? U. S. A.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			CAUSE OF DEATH Bleeding Esophageal Varices (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cirrhosis of the Liver (B) DUE TO, OR AS A CONSEQUENCE OF: Acute Alcoholism (C)		
19A. DATE OF OPERATION 2			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		
22. I certify that (I) (this hospital) attended the deceased from December 15, 1969 to December 29, 1969 that (I) (we) last saw the deceased alive on December 29, 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			20A. AUTOPSY? (Yes or No) yes		
23A. SIGNATURE Raymundo R. Corpuz M.D.			20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
23C. PHYSICIAN'S NAME (Type) Raymundo R. Corpuz M.D.			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
24A. BURIAL CREMATION, REMOVAL (Specify)			23D. ADDRESS 1514 Divison Street Baltimore, Md.		
24B. DATE 1/2/69			24C. NAME OF CEMETERY OR CREMATORY Baltimore National Cems		
24D. LOCATION (City, town, or county) (State) Baltimore Md.			25A. DATE REC'D BY HEALTH DEPT. JAN 2 1970		
25B. NAME OF REGISTRAR Robert E. Jager, Jr. D.O.			25C. FUNERAL DIRECTOR William Hamed Home 3981 Schenck St		



69 12992 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

69 12992

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>John Pulley</b>				2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.			
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>106 N. Pine St. (DOA)</b>				3. DATE PRONOUNCED DEAD Month Day Year Hour <b>12 21 69 10:15 AM</b>			
5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>402</b>							
6. SEX <b>Male</b>	7. RACE <b>Negro</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Balto.</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
9. DATE OF BIRTH <b>?</b>		10. AGE (In years lost birthday) <b>45</b>		E. STREET AND NUMBER <b>106 N. Pine St.</b>			
11. BIRTHPLACE (State or foreign country) <b>?</b>		12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <b>?</b>			
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		14B. KIND OF BUSINESS OR INDUSTRY		15. MOTHER'S MAIDEN NAME <b>?</b>			
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		17. SOCIAL SECURITY NO.		18. INFORMANT <b>Rev</b>		ADDRESS <b>Lipscomb, 760 W. Fayette</b>	
19. <b>5-7-68</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Fatty metamorphosis of the liver</b>				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C)			
20. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
20A. DATE OF OPERATION <b>2</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED				21. AUTOPSY? (Yes or No) <b>yes</b>	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>Russell S. Fisher</b>		EXAMINER'S NAME (Type) <b>Russell, S. Fisher, M.D.</b>		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>12-22-69</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>12/31/69</b>		24C. NAME OF CEMETERY or CREMATORY <b>mt Auburn</b>		24D. LOCATION (City, town, or county) (State) <b>Balto. Md</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 2 1970</b>		25B. NAME OF REGISTRAR <b>Robert E. Fisher, R.D.</b>		25C. FUNERAL DIRECTOR <b>Donald B. Oden, Balto. Md.</b>		ADDRESS	

VALLEY HILLS  
VALLEY HILLS  
VALLEY HILLS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		69 12993 CERTIFICATE OF DEATH		REG. NO. 69 12993	
1. NAME OF DECEASED (Type or Print) <b>Britton, Charles</b>			2. DATE AND HOUR OF DEATH <b>12-30-69 9:00 P. M.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <b>46 LUTHERAN Hospital</b> <b>730 Ashburton St.</b> <b>Baltimore, Md. 21216</b>			A. STATE <b>MARYLAND</b> B. COUNTY <b>1603</b>		
5. SEX <b>M</b>			6. RACE <b>N</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CUSTODIAN</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>COLLEGE</b>		8. DATE OF BIRTH <b>07-4-03</b>
13. FATHER'S NAME <b>HARRY BRITTON</b>			14. MOTHER'S MAIDEN NAME <b>BIRDIE ANDERSON</b>		9. AGE (In years last birthday) <b>66</b>
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>			16. SOCIAL SECURITY NO. <b>285-07-3820</b>		11. BIRTHPLACE (State or foreign country) <b>BALTO MD</b>
17. INFORMANT <b>JULIA STEWART</b>			ADDRESS <b>(SAME)</b>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Widespread carcinoma</b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19. DATE OF OPERATION <b>0</b>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <b>12-29</b> 19 <b>69</b> to <b>12-30</b> 19 <b>69</b> , that (I) (we) last saw the deceased alive on <b>12-30</b> 19 <b>69</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Violeta R. Gamarra R.M.D.</b>			23B. DATE SIGNED <b>12-30-69</b>		23C. PHYSICIAN'S NAME (Type) <b>VIOLETA R. GAMARRA M.D.</b>
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burned</b>			24B. DATE <b>1/3/70</b>		24C. NAME OF CEMETERY or CREMATORY <b>Mt Auburn</b>
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 2 1970</b>			25B. NAME OF REGISTRAR <b>E. Taylor, Jr.</b>		25C. FUNERAL DIRECTOR <b>James H. Hays</b>
25D. ADDRESS <b>1145 E. Taylor, Jr.</b>			25E. ADDRESS <b>1145 E. Taylor, Jr.</b>		

Exhibit 1

Julius Stewart  
1902  
Baltimore, Md.  
100 N. Howard St.  
02-4-03

M

N

(10)

Julius Stewart (Cont.)



7-250

BALTIMORE CITY HEALTH DEPARTMENT

69 12994

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

69 12994

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Beatrice Tyson

2. DATE  
OF  
DEATHKnown ☒ Estimated ☐

Month

Day

Year

Hour

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL  
OR INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)3. DATE  
PRONOUNCED DEAD

Month

Day

Year

Hour

12

29

69

5:00 p.m.

5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE

B. COUNTY

Maryland

6. SEX

female

7. RACE

colored

8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☒DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒NO ☐

9. DATE OF BIRTH

FOR 7-1904

10. AGE (in years  
last birthday)

65

# Under 1 Yr. If Under 24 Hrs.  
Months, Days, Hours, Min.

E. STREET AND NUMBER

2500 W. Baltimore St.

11. BIRTHPLACE (State or foreign country)

W. VIRGINIA S.C.

12. CITIZEN OF  
WHAT COUNTRY?

USA

13. FATHER'S NAME

JACOB JUMPIN

14A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

COOK

14B. KIND OF BUSINESS OR INDUSTRY

HOTEL

15. MOTHER'S MAIDEN NAME

SARAH MOOLY

16. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

NO

17. SOCIAL  
SECURITY NO.

215-16-9664A

18. INFORMANT

ADDRESS

MARIE ROCHOLLE 2500 W. BALTO ST

19. 412.4

CAUSE OF DEATH

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

Arteriosclerotic cardiovascular disease

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C) \_\_\_\_\_

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART 1 (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

NO

22A. EXTERNAL CAUSE WAS  
UNDERLYING ☐ OR CONTRIB-  
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY  
(APPROX.)22E. INJURY OCCURRED  
WHILE AT WORK ☐ NOT WHILE  
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATUREEXAMINER'S  
NAME (Type)

Werner U. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☐

Deputy Chief Medical Examiner

DATE SIGNED

12/30/69

24A. BURIAL CREMATION,  
REMOVAL (Specify)

24B. DATE

1/2/70

24C. NAME OF CEMETERY or CREMATORY

Mt Auburn

24D. LOCATION (City, town, or county)

Baltimore

(State)

25A. DATE REC'D BY HEALTH DEPT.

JAN 2 1970

25B. NAME OF REGISTRAR

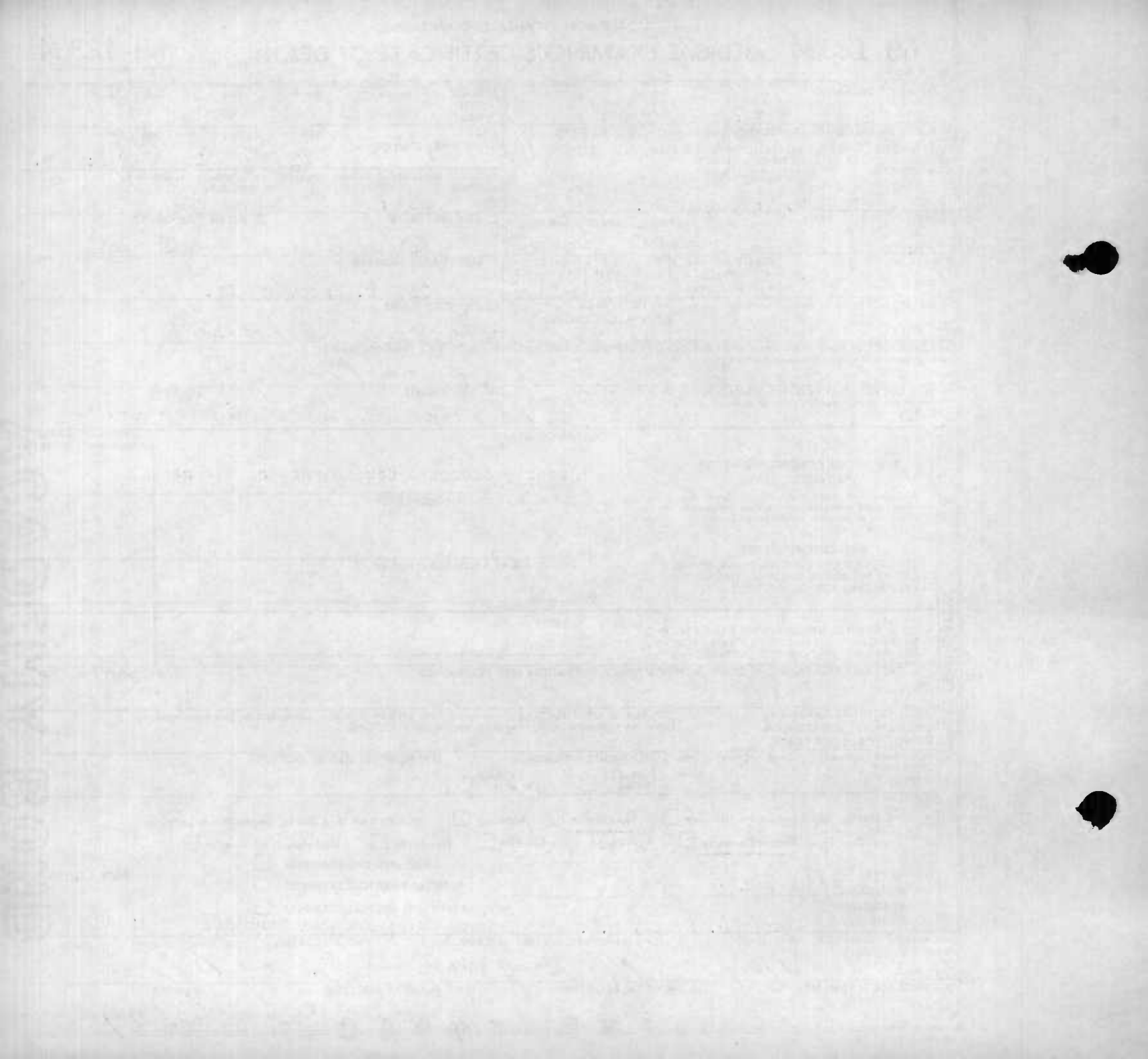
E. J. Spitz, M.D.

25C. FUNERAL DIRECTOR

J. H. Spitz, M.D.

ADDRESS

6387 Gilmor



K-460

## BALTIMORE CITY HEALTH DEPARTMENT

## 69 12995 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 69 12995

BIRTH NO.

1. NAME OF DECEASED (Type or Print) JOHN KELLER		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> 12 30 69 7:03 P. M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) JOHNS HOPKINS HOSPITAL (DOA)		3. DATE PRONOUNCED DEAD Month Day Year Hour December 30, 1969 7:03 P. M.	
6. SEX Male		7. RACE Negro	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH 7/12/13		10. AGE (In years lost birthday) 56	
11. BIRTHPLACE (State or foreign country) D.C.		12. CITIZEN OF WHAT COUNTRY?	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		14B. KIND OF BUSINESS OR INDUSTRY Construction	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO.	
13. FATHER'S NAME FRANK KELLER		15. MOTHER'S MAIDEN NAME NANCY ?	
18. INFORMANT Lillie Fowler		ADDRESS 809 N. Washington St	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) E9651X Gunshot wound of head		CAUSE OF DEATH Gunshot wound of head	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		(B) DUE TO, OR AS A CONSEQUENCE OF:	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) House	
22D. TIME OF INJURY (APPROX.) 12-30-69 6:40 P.M. m.		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 809 N. Washington Street 704		22F. HOW DID INJURY OCCUR? Shot by unknown assailant	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
DATE SIGNED 12/31/69			
24A. BURIAL CREMATION, REMOVAL (Specify) REMOVAL		24B. DATE 1/4/69	
24C. NAME OF CEMETERY or CREMATORY Tabernacle Church		24D. LOCATION (City, town, or county) (State) GREENWOOD, S.C.	
25A. DATE REC'D BY HEALTH DEPT. JAN 2 1970		25B. NAME OF REGISTRAR E. J. Taylor, M.D.	
25C. FUNERAL DIRECTOR J. L. Lock, Jr.		ADDRESS 1304 N. Central Ave	

ACADEMY BOND

PLAQUE

VALLEY PARK

1914

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				69 12996	
69 12996 CERTIFICATE OF DEATH				REG. NO. _____	
BIRTH NO. _____		1. NAME OF DECEASED (Type or Print) <u>NAOMI JACKSON</u>		2. DATE AND HOUR OF DEATH <u>12/29/69</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <u>9 MONTCEBELLO STATE HOSP.</u>			A. STATE <u>MD</u> B. COUNTY <u>807</u>		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			C. CITY OR TOWN <u>BALTO.</u>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER <u>1620 E. Preston St</u>		
5. SEX <u>F</u>	6. RACE <u>C.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/15/08</u>	9. AGE (In years lost birthday) <u>61</u>	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CUSTODIAN</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>FOOD FAIR</u>	11. BIRTHPLACE (State or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME <u>?</u>			14. MOTHER'S MAIDEN NAME <u>GERTRUDE HENSON</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>216-16-6415</u>	17. INFORMANT ADDRESS <u>John BRUMMELL 1425 E. LAFAYETTE</u>		
18. <u>193X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Carcinoma of thyroid with generalized metastasis.</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 1/2 years.</u>
			(B) DUE TO, OR AS A CONSEQUENCE OF:		
			(C) DUE TO, OR AS A CONSEQUENCE OF:		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>Terminal Pneumonia</u>					
19A. DATE OF OPERATION <u>2/1</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>Yes</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>8-7</u> 19 <u>67</u> to <u>12-29</u> 19 <u>69</u> that (I) (we) lost saw the deceased olive on <u>12-29</u> 19 <u>69</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>T.B. Fan, M.D.</u>			23B. DATE SIGNED <u>Dec. 29, 1969</u>		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>
23C. PHYSICIAN'S NAME (Type) <u>KIAO-SIONG TAN M.D.</u>			23D. ADDRESS <u>MONTCEBELLO STATE HOSPITAL</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>	24B. DATE <u>1-3-70</u>	24C. NAME of CEMETERY or CREMATORY <u>MT. CALVARY</u>		24D. LOCATION (City, town, or county) (State) <u>A.A. County, MD.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 2 1970</u>		25B. NAME OF REGISTRAR <u>John F. Galt, M.D.</u>		25C. FUNERAL DIRECTOR ADDRESS <u>Joseph G. Hock, Jr. 13047 Central Ave</u>	





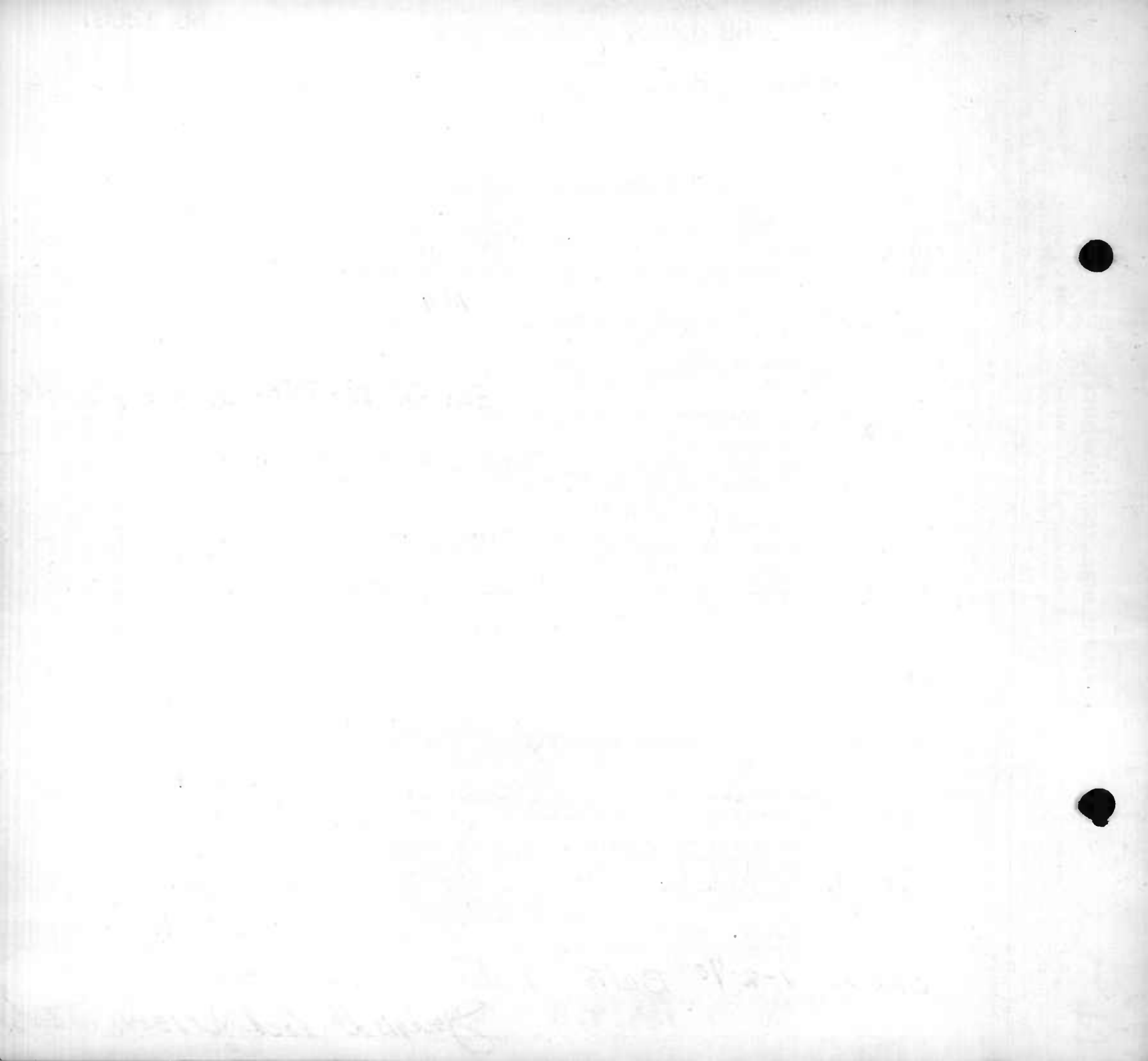
# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

## BALTIMORE CITY HEALTH DEPARTMENT 69 12997 CERTIFICATE OF DEATH

REG. NO. 69 12997

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>CHARLES HENRY JONES</b>		2. DATE AND HOUR OF DEATH <b>DECEMBER 28, 1969 12:55 A.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>JOHNS HOPKINS HOSPITAL</b>			4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>833</b> C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>2441 E. BIDDLE ST.</b>		
5. SEX <b>MALE</b>	6. RACE <b>N26RO</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11/21/14</b>	9. AGE (In years last birthday) <b>55</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CONSTRUCTION WORKER</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>md</b>		11. BIRTHPLACE (State or foreign country) <b>md</b>	
13. FATHER'S NAME <b>CHARLES JONES</b>			14. MOTHER'S MAIDEN NAME <b>ESSIE FRANKLIN</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>ELVIRA WATERS 2236 E. Parale</b>	
18. <b>492X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE <b>SEVERE Bullous EMPHYSEMA</b> DUE TO, OR AS A CONSEQUENCE OF: (B) <b>PNEUMONIA</b> DUE TO, OR AS A CONSEQUENCE OF: (C) _____		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>8 YEARS</b> <b>1 WEEK</b> <b>1 MONTH</b>		
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>Yes</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from <b>DECEMBER 27 1969</b> to <b>DECEMBER 28 1969</b> , that (1) (me) last saw the deceased alive on <b>DECEMBER 28 1969</b> and that in (my) (foot) opinion death occurred on the date and hour and from the causes stated above. (1) (me) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Stephen C. Achuff MD</b>				23B. DATE SIGNED <b>December 28, 1969</b>	
23C. PHYSICIAN'S NAME (Type) <b>STEPHEN C. ACHUFF</b>				23D. ADDRESS <b>THE JOHNS HOPKINS HOSPITAL</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>	24B. DATE <b>1-2-70</b>	24C. NAME OF CEMETERY or CREMATORY <b>Balto' National</b>		24D. LOCATION (City, town, or county) (State) <b>5501 FREDERICK AVE</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 2 1970</b>		25B. NAME OF REGISTRAR <b>Robert J. Baker, MD</b>		25C. FUNERAL DIRECTOR <b>Joseph B. Lock Jr. 1304 N. Central</b>	





FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 69 12998	
BIRTH NO. 69 12998		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>TRAYERS</b> <b>Matthews, Howard</b>		2. DATE AND HOUR OF DEATH <b>12/28/69</b> <b>7:55 P.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>33</b> <b>The Johns Hopkins Hospital</b>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>md</b> B. COUNTY <b>1004</b> C. CITY OR TOWN <b>Balto.</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>419 E. Biddle St.</b>			
5. SEX <b>Male</b>	6. RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1-25-21</b>	9. AGE (In years lost birthday) <b>48</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>LABORER</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>md</b>		11. BIRTHPLACE (State or foreign country) <b>md</b>	
13. FATHER'S NAME <b>John West Todd</b>		14. MOTHER'S MAIDEN NAME <b>ELIZA TRAYERS</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>216-62-7183</b>		17. INFORMANT <b>MAGGIE BELL</b>	
18. <b>146.01</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).  19A. DATE OF OPERATION <b>3/69</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>ca tonsillar area</b>		20A. AUTOPSY? (Yes or No) <b>Yes</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <b>NO</b>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>---</b>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>---</b>	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) <b>---</b>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <b>---</b>	
22. I certify that (1) (this hospital) attended the deceased from <b>12/28</b> 19 <b>69</b> to <b>19</b> 19 <b>69</b> , that (2) (we) last saw the deceased alive on <b>12/28</b> 19 <b>69</b> and that in (3) (our) opinion death occurred on the date and hour and from the causes stated above. (4) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Michael Jones</b>				23B. DATE SIGNED <b>12/28/69</b>	
23C. PHYSICIAN'S NAME (Type) <b>Michael Jones, M.D.</b>		23D. ADDRESS <b>The Johns Hopkins Hospital</b>			
24A. BURIAL CREMATION, REMOVAL <b>Burial</b>	24B. DATE <b>1/3/69</b>	24C. NAME OF CEMETERY or CREMATORY <b>Lena Rds. Md.</b>		24D. LOCATION (City, town, or county) (State) <b>---</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 2 1970</b>		25B. NAME OF REGISTRAR <b>Dr. E. Gable, R.D.</b>		25C. FUNERAL DIRECTOR <b>Joseph J. Locke</b>	
				ADDRESS <b>1304 N. Central</b>	

Report of the  
Board of Directors

1910

3/10

1910

Report of the  
Board of Directors

1910

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

69 12999

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO.

69 12999

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Bernice Johnson

2. DATE AND HOUR OF DEATH

12/28/69

M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

90 Mt Sinai Nursing Home  
4613 Park Heights Ave  
Baltimore MD 21215

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

MD

C. CITY OR TOWN

Balto

D. INSIDE CITY LIMITS?

YES ☒

NO ☐

E. STREET AND NUMBER

1105 E Federal Street

5. SEX

Female

6. RACE

Negro

7. MARRIED ☐ NEVER MARRIED ☐

WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

8-20-1900

9. AGE (In years last birthday)

69

If Under 1 Yr. Months: Days:

If Under 24 Hrs. Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

LAUNDRESS (R)

10B. KIND OF BUSINESS OR INDUSTRY

St. Joseph Hosp

11. BIRTHPLACE (State or foreign country)

S.C.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

George MAYFIELD

14. MOTHER'S MAIDEN NAME

LENA YOUNG

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

Wm. Johnson 1105 E Federal ST

18. 170.1 I

CAUSE OF DEATH

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A):

19A. DATE OF OPERATION

June 69

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

Malignant

20A. AUTOPSY? (Yes or No)

NO

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At Work ☐

Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 12/2 to 12/28 1969, that (I) (we) last saw the deceased alive on 12/22/69 and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

George Vash MD

Attending Phys. ☒

Med. Director ☐

Staff Phys. ☐

23B. DATE SIGNED

23C. PHYSICIAN'S NAME (Type)

VASH

23D. ADDRESS

206, S. Gilman

24A. BURIAL CREMATION REMOVAL (Specify)

BURIAL

24B. DATE

1/2/69

24C. NAME OF CEMETERY OR CREMATORY

Mt. Calvary

24D. LOCATION

D. D. County Md

(City, town, or county) (State)

25A. DATE REC'D BY HEALTH DEPT.

JAN 2 1970

25B. NAME OF REGISTRAR

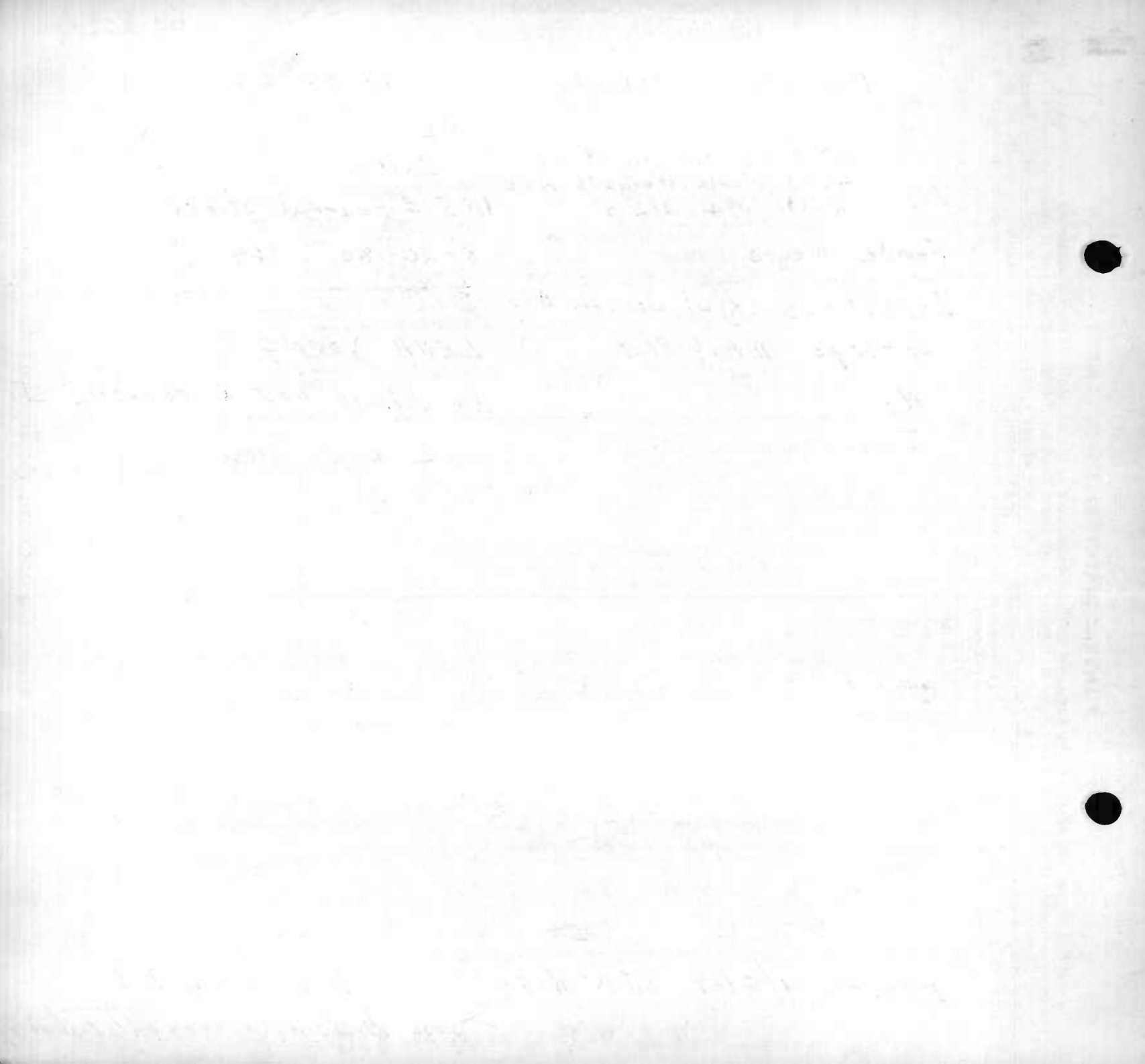
Regina E. Taylor

25C. FUNERAL DIRECTOR

Joseph S. Locks Jr

ADDRESS

1304 N. Central Ave



1  
P-623

69 13000

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 69 13000

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>Annie Bell PRESTON</b>		2. DATE OF DEATH Known <input type="checkbox"/> Estimated <input type="checkbox"/>		Month Day Year Hour	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>659 George St.</b>		3. DATE PRONOUNCED DEAD <b>12 28 69</b>		Month Day Year		Hour <b>10:05 A.M.</b>	
6. SEX <b>Female</b>		7. RACE <b>Negro</b>		B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		C. CITY OR TOWN <b>Balto.</b>	
9. DATE OF BIRTH <b>July 7, 1902</b>		10. AGE (In years last birthday) <b>67</b>		If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
11. BIRTHPLACE (State or foreign country) <b>Summerton, S. C.</b>		12. CITIZEN OF <b>U.S.A.</b>		13. FATHER'S NAME <b>Joe Mc Bride</b>		E. STREET AND NUMBER <b>659 George St.</b>	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Domestic</b>		14B. KIND OF BUSINESS OR INDUSTRY <b>Household</b>		15. MOTHER'S MAIDEN NAME <b>Celie Mc Bride</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>	
17. SOCIAL SECURITY NO. <b>217-20-9996</b>		18. INFORMANT <b>Lula M. DeLaine</b>		ADDRESS <b>South Carolina Route 2 Box 2 Mannings</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19. <b>412.4</b>		CAUSE OF DEATH <b>Arteriosclerotic cardiovascular disease</b>		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) DUE TO, OR AS A CONSEQUENCE OF:			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				(C) DUE TO, OR AS A CONSEQUENCE OF:			
20A. DATE OF OPERATION <b>0</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) <b>no</b>			
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>Russell S. Fisher, M.D.</b>		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
NAME (Type)		DATE SIGNED <b>12-29-69</b>					
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>Jan. 2, 1970</b>		24C. NAME OF CEMETERY or CREMATORY <b>Liberty Hill AME Cem.</b>		24D. LOCATION (City, town, or county) (State) <b>Summerton, South Carolina</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 2 1970</b>		25B. NAME OF REGISTRAR <b>Donald E. Glover</b>		25C. FUNERAL DIRECTOR <b>1701 N. Patt. Pk. Ave.</b>		ADDRESS	

